South East London
Palliative and End of Life
Care Coordinating Group

South East London
Cancer Network
NHS

Marie Curie
Cancer Care

Delivering Choice Programme®
Working together to provide
patient choice at the end of life

South East London Palliative and End of Life Care Education and Training Strategy

Meeting the Education and Training Needs of the Health & Social Care Workforce Involved in the Care of Patients and Carers at the End of Life

October 2009

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ACKNOWLEDGEMENTS

Information was collated and this strategy written by **Kath McDonnell, South East London Palliative and End of Life Care Programme Manager**, South East London Cancer Network Palliative and End of Life Care Programme.

Additional contributions were made by:
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INTRODUCTION

Palliative and end of life care involves care to all those with *any* advanced, progressive, incurable illness, enabling each individual to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

A workforce that is skilled and confident in the provision of palliative and end of life care underpins the development of reliable, responsible and sustainable services for those patients with life-limiting disease. The development of robust and appropriate education provision for palliative and end of life care is therefore vital to ensure high quality care for these patients. This strategy, in relation to the palliative and end of life care of adult patients and their families, and through collaboration between the Marie Curie Delivering Choice Programme and the South East London Cancer Network's Palliative and End of Life Care Programme has been created in recognition of this need.

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FOREWORD

The end of life is something all of us will encounter in the departure of loved ones and friends, and ultimately it will be a journey that each and every one of us experiences. How that experience impacts on us is therefore of ultimate importance. A distressing experience impedes the grieving and acceptance process and can contribute to the longer-term health problems faced by family and friends. As professional health and social care providers we have a duty to try and get the end of life experience right for all those involved; patients, family and friends, and also the attending staff. In order to do this we have to optimise the use of all available and relevant resources so that we are offering timely and appropriate interventions and care. Supportive mechanisms need to be in place to help ensure that we achieve this laudable aim. Effective education and training in the various aspects of End of Life Care (EOLC) is essential to ensuring we have knowledgeable and skilled staff who are able to assess and meet the needs of individual patients.

It is recognised that there is a lot of very good and ongoing EOLC work, and that high quality care is being delivered, but following the National EOLC Strategy (July 2008) it became apparent that further attention to workforce development was required. The purpose of this Education and Training Strategy is to highlight the various types and levels of education and training required by members of the health and social care multidisciplinary team in order to build on and enhance the existing good EOLC work. This will then ensure a consistent and comprehensive approach to care delivery so that patients receive a high quality seamless service.

This strategy is relevant to all those involved in or who have an interest in EOLC. In particular, the National EOLC Strategy states that action responses will be sought from:

- Professional regulating bodies such as the General Medical Council (GMC), and the Nursing and Midwifery Council (NMC), etc.
- Universities providing medical, dental, nursing, and allied health professionals education and training
- Strategic Health Authorities in ensuring that resources are directed toward the acquisition of priority skills by the workforce
- Local Service Commissioners
- Local Service Providers. Both commissioners and providers need to ensure a workforce that is competent to deliver EOLC
- Individual practitioners and members of the multidisciplinary health and social care team.

Everyone involved in education and training delivery, and also those directly associated in a supporting role, for example through commissioning education, providing clinical placements, and by conducting staff appraisals etc., share the responsibility for achieving real progress in achieving the aims of the strategy.

- Individual staff have a responsibility for continuing professional development (CPD) in reviewing, renewing, and enhancing the competences, knowledge and skill, deployed in the required job role.
- Employers need to commission effective education and training programmes to ensure value-for-money return in that staff are helped to acquire the necessary competences required for the job role(s).
- Employers need to maintain a strong commitment to investing in the recruitment and future development of staff.
- Education and training providers must be responsive to the changing needs of society, the requirements of professional registrant bodies, and the imperatives of government policies.

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EXECUTIVE SUMMARY

Aims

1. The aims of this strategy are
    - to ensure that a full range of education and training related to the adult end of life care pathway is available across South East London to meet the needs of our health and social care workforce
    - to enable those responsible for end of life care education and training commissioning to procure comprehensively from a full range of education providers in a systematic and strategic manner.

Background

2. The work that underpins this strategy was begun by the South East London Cancer Network via its Palliative and End of Life Care Coordinating Group and then developed by way of the Marie Curie Delivering Choice Programme's Education and Training work stream.

Context and Drivers of Change

The National Context – a motivation for change

3. The development of the end of life care workforce and its education and training is a major aspect of the *National End of Life Care Strategy* (DoH, 2008), with a focus on:
    - A cultural shift in workforce attitude and behaviour that entails a movement away from the belief that death is a failure of care
    - Training that resolves all major deficiencies in the skills and knowledge of the health and social care workforce having contact with end of life care patients
    - Programmes to enhance pre- and post-registration professional training, rather than focusing on an expansion of the workforce
    - Staff taking personal responsibility for the reduction in gaps in their skills and competencies for delivering end of life care

4. *Quality Markers and Measures for End of Life Care* (DoH, 2009) seeks to provide a national approach to improving the quality of end of life care by providing guidance to commissioners, performance managers and service providers. This quality framework includes quality markers and measures relating to training and these are aimed at Strategic

Health Authorities, Primary Care Trusts and care providers including acute providers, community nursing and medical services, out of hours providers and community specialist palliative care teams.

5. *Common core competences and principles for health and social care workers working with adults at the end of life* (DoH, Skills for Health, and Skills for Care, 2009) describes the competencies needed to ensure that all health and social care professionals are confident and able to work with patients at end of life. The document is broken into four broad areas:
    - Communication Skills
    - Assessment and Care Planning
    - Symptom Management
    - Advanced Care Planning

    The *National End of Life Care Strategy* (DoH, 2008) suggests that consideration should be given as to how these four core competency areas are broken down to reflect the knowledge, skills and attitudes required to undertake each of the roles within the end of life care pathway.

6. From January 2010, the Department of Health's e-learning for End of Life Care project (ELCA) will deliver accessible, easily digestible e-learning materials for the four core competency areas identified in the *National End of Life Care Strategy* (DoH, 2008). These are intended to complement and support a variety of learning experiences; including experiential and face-to-face learning.

7. In early 2009 the National Council for Palliative Care (NCPC) launched a major new training initiative: *Care to Learn - the NCPC End of Life Care Training Programme.* It is available for purchase as a training pack and is designed to be delivered in the workplace in a flexible and practical format that fits staff and organisational needs.

8. Macmillan Cancer Support provides a number of free web-based education resources on their Learning Zone website.

9. Through funding from Connected and the national End of Life Care Programme and in collaboration with the North East London Cancer Network, South East London has been chosen to deliver a one-year project to develop all levels of communication skills training for the end of life care health and social care workforce. This project will complete in autumn 2010.

10. The work of Omega, the National Association of End of Life Care will seek to promote excellence in end of life care through a number of areas, including the delivery of education and training to generalists in end of life care.

11. Other national drivers include:
    - The National Audit Office (NAO) report on the national End of Life Care survey (2008) highlighted a lack of training in end of life care, for doctors and nurses in particular during pre-registration courses. Other professional groups that were identified as needing a particular focus for educational support included GPs and care home staff.
    - *Modernising the Social Care Workforce* (2000) concluded that the domiciliary care workforce received little attention regarding education and training, despite the fact that the majority of front line care is provided by this group.
    - The General Social Care Council (GSCC) has made significant progress in setting clear professional standards for social workers. In 2007, the government announced that home care workers would be the next group of social care workers to be registered. This should occur from early 2010 and will begin to allow for the development of standards for the work of this staff group.
    - *Working to Put People First*: The Strategy for the Adult Social Care Workforce in England, 2009
    - *Modernising Medical Careers: Third Report of Session 2007–08*, House of Lords Health Committee, 2008
    - *Modernising Nursing Career: Setting the Direction*, Department of Health, 2006

The Pan-London Context – creating opportunities for change

12. For London, the delivery of Darzi's end of life care recommendations is being driven by Healthcare for London in partnership with Primary Care Trusts and NHS London. The Healthcare for London End of Life Care Project is likely to include the development of educational packages related to end of life care. Part of the intention of its overall work is to create a shift in attitudes and practice in the acute sector to support the identification of patients who are dying.

13. In September 2008 NHS London launched *'Workforce for London - a Strategic Framework'*, London's first ten-year vision for the development of its healthcare workforce. Within this framework and through diagnostic work undertaken in 2007, NHS London identified the

current system for planning, educating, developing and deploying staff as unfit for purpose. The proposed solution is to develop a new approach to workforce planning and education commissioning via the principles advocated in world-class commissioning. Work is underway to transform existing processes and structures.

The South-East London Context

Relevant demographics in South East London

14. Between 2004 and 2006 there were 16,805 deaths in males and 17,693 deaths in females of all ages across South East London. Although an undefined number of these will be deaths in childhood, it is expected that the majority will reflect deaths in adulthood. The largest causes of deaths were cancer, respiratory diseases and circulatory diseases particularly coronary heart disease and stroke for both males and females.

15. The distribution of place of death per setting in South East London is similar to the average figures for the United Kingdom. These statistics illustrate that care in the last days and weeks of life can occur in any health and social care setting; meaning that a diverse range of workforce are exposed to the provision of end of life care and should therefore have access to appropriate end of life care education and training.

The SE London Workforce – beginning to establish numbers and needs

16. The workforce involved in end of life care is very large, consisting of health and social care staff working in a variety of settings. They are employed by many different types of employers and cover diverse roles including doctors, nurses, social care staff and a wide range of allied health professionals. Of these, the specialist palliative care workforce is relatively small compared to the total number of health and social care professionals who deliver end of life care. Support staff can also frequently be exposed to work that involves meeting people with life-limiting illnesses. Investigative work has enabled an estimate of numbers of the whole end of life care workforce for South East London, which can be found in full in section 3.2 of this strategy.

17. As recommended within the *National End of Life Care Strategy* (DoH, 2008) and for the purposes of implementing this education strategy, the workforce should be broken into three groups: A, B and C:

	Group A	**Group B**	**Group C**
Description of work	Work in specialist palliative care / hospice and essentially spend their working lives dealing with end of life care	Frequently deal with end of life as part of their role	Work as specialists or generalists within other services who infrequently have to deal with end of life care
Example roles	Palliative nurses and physicians; specialist and allied health professionals; hospice staff	A&E secondary care staff; acute medicine; care of the elderly; cardiology; oncology; renal medicine (see section 3.2.2 for full list)	Professionals working in secondary or community care including care home, day care and social care (see section 3.2.2 for full list)
Minimum levels of knowledge and skill	All should have the highest level of knowledge, skills and understanding through specialist training as part of specialist registration or CPD, including all competencies listed in number 5 of this executive summary	Need to be supported to enable them to develop or apply existing skills and knowledge through CPD or training. This group has the greatest potential training need. Should attain all competencies listed in number 5 of this executive summary	Must have a good basic grounding in the principles and practice of end of life care and be enabled to know when to refer for expert advice

18. It is difficult to establish the headcounts for staff groups B and C and absolute numbers can only be determined at an organisational level. In line with the information above, relevant minimum levels of training regarding end of life care should be incorporated into the Knowledge and Skills frameworks for individual posts and then access by the worker to relevant courses enabled.

19. With over two-thirds of the social care workforce working in the private and third sectors, 60% of their 35,000 (estimated) employers nationally are classified as micro (having fewer than 10 employees) and a further 30% small (fewer than 50). Any strategy that seeks to make a significant impact on the quality of care provided by this workforce must therefore recognise the challenge of ensuring these small-scale employers appropriately train their employees in end of life care.

20. The current movement towards the introduction of personal budgets for care provision means that more people using services may chose to employ professional care directly.

While NHS and local authority professionals will hopefully be able to guide patients and carers to employ care staff / teams with the correct skills to meet their needs, this 'open-market' will create additional challenges in ensuring all social care staff dealing with end of life patients are supported and developed to do their job well.

The South East London Workforce – a training needs assessment

21. A scoping exercise undertaken by the Marie Curie Delivering Choice Programme revealed the following *general themes* relating to the needs of staff for end of life care knowledge and skills:
    - The need to know how to recognise that the patient is entering the end of life phase
    - The need to recognise that the patient is now actively dying (diagnosing dying)
    - The need to understand the relevance and applicability of palliative and end of life care skills to patients with non-cancer
    - The need for palliative care training and support to front line generalist staff across all settings
    - The need to understand collaborative working between generalist and specialist palliative care services
    - The need to know how and when to have a discussion with a patient about their needs and preferences for their end of life care, and how to record it (e.g. Advance Care Planning, Preferred Priorities for Care)
    - The need for staff to be released for education and training in end of life care as a priority
    - The need to understand how funding mechanisms work to enable patients to be transferred to / remain in their place of choice (e.g. NHS continuing care funding).

22. Additional themes identified through this scoping by GPs and District Nurses included the need for training in:
    - symptom management
    - medicines management
    - syringe driver initiation and management
    - cultural, social and spiritual care
    - working with families in distress
    - Advance Decisions to Refuse Treatment (ADRT).

Care home managers raised similar issues for their staff but also expressed the need for their staff to know how to:

- implement and explain the Gold Standards Framework
- approach relatives of patients when an ADRT was to be implemented

Palliative and End of Life Care Education and Training Provision

Introduction: Preferred education delivery and methods of learning

23. Whilst there are increased opportunities for and access to e-learning, it is also evidenced that e-learning is more effective when combined with classroom based learning. It has been noted that, in order to provide high-quality care at end of life, professionals themselves must be comfortable with death and dying and that facing situations without adequate training may lead to anxiety about death and negative attitudes towards caring for the dying. This clearly demonstrates that end of life care education and training must involve not only the supply of appropriate knowledge but opportunities to change the attitudes, beliefs and behaviours of care workers with regard to death, dying and end of life care.

24. The provision of good education and training in palliative and end of life care will need to involve blended learning through a mixture of:

- e-learning opportunities, particularly to support pre-course preparatory learning
- face to face education delivery using didactic learning methods for instilling evidence-based knowledge regarding factual palliative care information, for example the use of drugs in the control of symptoms
- face to face transformative learning methods for changing attitudes and behaviours about end of life care, and so improving the quality of patient centred care.

25. Practice education is the term used to describe the part of a professional educational programme in which students gain ‘hands-on’ experience of working with patients under the supervision of a qualified practitioner. Research evidence suggests that practice education allows students to practise problem-solving skills, to observe and question the application of practice, and to gain insight into the reality of work and the pressures of the work environment. In addition, it has been found that there are opportunities provided by practice education for students to develop ‘attitudes and interpersonal skills essential for professional practice’. Such learning methods would clearly be valuable in palliative and end of life care education for the changing of attitudes and behaviours relating to death, dying and end of life care.

26. Working in teams has been an integral part of the philosophy of palliative care since its early beginnings, enshrined in its standards and embedded in its practice. Providers of end of life care education and training should ensure that their education programmes include opportunities for interdisciplinary learning and that these courses include opportunities for team based clinical case analysis and learning.

27. Although it is recognised that, in health and social care, there are already a significant number of topics required for coverage in mandatory training and induction programmes, the information provided in this strategy demonstrates the importance of inclusion of end of life care education in compulsory training programmes.

Mapping and analysis of current palliative and end of life care courses for SE London

28. A mapping exercise of palliative and end of life care training courses run in 2007 / 2008 revealed a large number of courses delivered across South East London. The mapping template enabled the disclosure of the following information relating to these courses:

- Title of courses and course outline
- For each education and training course:
  - Which professional groups the course is aimed at
  - The geographical and / or organisational catchment area for potential students
  - Which professionals deliver the course
  - Whether the course is validated
  - The length of the course
  - Number of places available
  - Frequency of delivery
  - Cost per student or course
- Issues and obstacles to education provision

29. Mapping revealed that, for 2007-8, there was delivery of a significant number of education and training opportunities, with a total of at least **164** available to staff in South East London, ranging from short sessions within inductions to fully accredited academic modules and courses. However, these were not coordinated across the sector. Of these education and training opportunities, 21 were described as accredited courses. In addition, **4** hospital based specialist palliative care teams and **4** voluntary sector hospices provided the

30. Mapping suggests that education and training opportunities already exist for South East London that are generally in line with the end of life care pathway. That said future planning of the delivery of education and training will require considerable coordination to ensure equitable access across the whole sector and sufficient coverage of all topics relating to the care pathway.

31. The mapping reveals that specialist palliative care professionals deliver a large proportion of end of life care education and are therefore an essential resource due to their expertise. It is therefore vital that their release from practice is facilitated so that they can teach on both non-accredited and accredited courses.

32. Although this mapping omitted to request information regarding the source of funding for the delivery courses, intelligence outside of this exercise confirms that opportunities for meeting the costs for delivery of end of life care training are variable between education providers. In particular hospices rely on unpredictable multiple sources of funding.

33. A number of barriers to education and training delivery were identified via this mapping including:

- Uncertainty around funding and decreases in funding
- Lack of protected time for delivering or attending training, including lack of administrative support
- Poor attendance, lack of prioritisation for training, poor attitude to training
- Lack of understanding between providers of each others organisational function and need

Other future and current opportunities for end of life care workforce development in South East London

34. From March 2009, King's health partners have been formally accredited as one of the United Kingdom's first Academic Health Science Centre. It will be the challenge of this new body to make full use of its potential to revolutionise the way that health care is designed and delivered, both for the local population and beyond.

35. Within the South East London Marie Curie Delivering Choice Programme (MCDCP), and in conjunction with St Christopher's Hospice, a work stream has focused on the development of a proposal for the improvement of end of life care in care homes, primarily through the implementation of Gold Standards Framework in Care Homes. Success of this proposal and therefore the improvement of the skills and knowledge of care home staff depends on individual Primary Care Trusts extending funding for Care Home Facilitator posts within their localities beyond March 2010.

Current arrangements for education commissioning and funding

36. Nationally there is no one single process for the funding of the education and training of all health and social care professionals and care givers. It is indeed perhaps inevitable that this should be the case for a workforce that is employed by different types of organisations- statutory, private and voluntary, and who come from many different professional groupings, with some qualified and others not. In essence, the funding of education and training is generally separate for healthcare staff and social care staff. Details relating to these funding streams are described in section 4 of this strategy.

37. In relation to NHS London, their *Workforce for London Strategy* has led to a review of existing education commissioning processes for the capital. This will lead to new opportunities for funding, in particular in relation to investment for Continuing Personal and Professional Development. In addition, NHS London plans to set up an Education Commissioning Hub for the capital. They have presented four possible models for managing education commissioning across London and are currently consulting with stakeholders for their views on these options. The final decision will influence how this South East London end of life care education strategy and its recommendations might be implemented.

38. It is recommended that the commissioning of palliative and end of life training and education be overseen at sector level rather than being devolved wholly to individual Primary Care Trusts and other local organisations.

39. Many of the palliative and end of life courses are delivered by providers other than the Higher Education Institutions, such as the voluntary sector hospice and other palliative care teams. It is important for education commissioners to ensure they engage with all education providers across South East London.

40. Whilst funding streams tend to be available for the education and training of NHS and local authority social care staff, domiciliary care and care home staff working for private organisations tend to be fully reliant on their employer to cover the cost of training. Commissioners should therefore ensure that contracts with independent social care organisations contain funding and provision for providing education and training in end of life care.

41. Some funding attached to the publication of the *National End of Life Care Strategy* has been allocated to Strategic Health Authorities for the development of end of life care education and training. For NHS London, this funding will be devolved in two stages within MPET funding allocations to Primary Care Trusts, with a first sum during the 3rd Quarter of 2009 and then the second sum in 2010/11. Although the amounts allocated to each Primary Care Trust have not yet been clarified, it will be on a per capita basis and it can therefore be assumed that the total amount for 2009/10 and 2010/11 for South East London should be as follows:

Lambeth	£92,767
Southwark	£78,808
Lewisham	£77,560
Greenwich	£67,839
Bexley	£51,396
Bromley	£74,573

Summary of recommendations

Please note that a summary of recommendations by category of organisation can be found at page 101.

No.	Recommendation	Page of strategy
1	There should be widespread acknowledgement that all Specialist Palliative Care Teams are and should be an educational resource for generalist end of life health and social care providers.	32
2	Education commissioners and providers should aim to create and deliver education and training packages which allow staff from different settings to learn together.	32
3	Primary Care Trusts and care providers within South East London should implement the national end of life care Quality Markers and Measures (2009) that are relevant to them.	33
4	Primary Care Trusts and other relevant bodies should encourage NHS London to adopt the national end of life care Quality Markers and Measures (2009) that are relevant to them.	33
5	All individual health and social care workers in South East London should be supported to determine their education and training needs in end of life care by referring to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009).	37
6	All relevant health and social service managers in South East London should determine the education and training needs in end of life care of their staff by referring to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009).	37
7	All South East London organisations that deliver end of life care education and training should refer to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009) when determining educational programmes, course curricula, outcomes and in designing course material. They should ensure that their courses cover the knowledge, skills and attitudes required for health and social care staff to deliver all aspects of the end of life pathway of care (national End of Life Care Strategy, 2008).	37
8	Education commissioners in South East London should ensure that there is access to a full range of end of life care education and training courses, in line with the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009).and the knowledge and skills needed to deliver the end of life care pathway (national End of Life Care Strategy, 2008).	37

No.	Recommendation	Page of strategy
9	Education commissioners and providers should ensure education and training in palliative and end of life care is available to domiciliary care workers as a priority.	43
10	Primary Care Trusts and local authorities should ensure that, when commissioning care packages for people in need of end of life care, the care agency guarantees its workers have the necessary knowledge, skills and attitudes to do the job. This requirement should be made explicit within contracts.	43
11	Where care packages are sub-contracted to independent provider organisations their workers should also have accessed relevant end of life care training packages from local expert education and training providers.	43
12	Local authority and independent domiciliary care agencies should ensure their staff have received appropriate training in end of life care.	43
13	Smaller domiciliary care employers should receive support in understanding the educational needs of their staff and how they can find appropriate end of life care development and training. This might be achieved through dialogues between service commissioners and the service agency in their contracting process.	43
14	To ensure that local health and social care services are delivering culturally sensitive end of life care relevant to local populations, the emphasis within education programmes should be for practitioners to ask end of life care patients their preferences, regarding their cultural and other needs.	49
15	Employers should refer to this Workforce Group framework (p53 or End of Life Care Strategy, DOH, 2009) in determining which level of skill and knowledge a particular employee should attain.	52
16	Whether NHS staff are to receive Group B or Group C level training must be determined at an organisational level. Relevant minimal levels of training regarding end of life care should then be incorporated into the Knowledge and Skills frameworks for individual posts and access by the worker to relevant courses enabled.	57
17	Organisations in South East London, such as Primary Care Trusts, who commission care from private care agencies and care homes for adult patients who may develop a need for end of life care, should require from them a workforce that is appropriately trained in end of life care.	58
18	Independent sector organisations and teams providing care to end of life care patients in South East London should ensure their staff have access to and undertake appropriate training and providing them with the minimum level of knowledge and skills for their role.	59
19	Whether Local Authority staff are to receive Group B or Group C level training must be determined at an organisational level. Relevant minimal levels of training regarding end of life care should then be incorporated into the Knowledge and Skills frameworks for individual posts and access by the worker to relevant courses enabled.	60

No.	Recommendation	Page of strategy
20	Whether Social Care staff are to receive Group B or Group C level training must determined at an organisational, local authority or Primary Care Trust level. Relevant minimal levels of training regarding end of life care should then be incorporated into the Knowledge and Skills frameworks for individual posts and access for the worker to relevant courses enabled.	62
21	Employers of and individuals in support roles (including such roles as caterers, porters, mortuary staff, housekeepers, drivers, grounds men, administrators and fundraising staff) will need to consider which end of life care competencies relate to the individual post holder and determine educational needs accordingly.	63
22	Palliative and end of life care education providers should consider developing their education programmes to include the needs of support workers that come into contact with end of life care patients.	63
23	The education needs of and training resources for informal carers in end of life care should be considered in a separate piece of work in close consultation with existing relevant User Partnership Groups within South East London and with links to the work of Omega / Caring with Confidence.	64
24	As recommended in the national End of Life Care Strategy, Primary Care Trusts should develop local strategies for promoting public awareness with regard to issues around death, dying and end of life care.	64
25	Commissioners and providers of education and training should agree to the design and delivery of multi-professional, multi-agency training programmes based not only on the national competencies and end of life care pathway, but with particular consideration of the findings of Marie Curie Delivering Choice Programme Training Needs Assessment for South East London.	67
26	Organisations that employ and / or commission the end of life care workforce should ensure that training needs assessments are performed on a regular basis to inform the commissioning of programmes of education. This may form an annual review of end of life care training needs identified within staff appraisal systems.	67
27	Health and social care service managers in South East London should enable relevant members of their workforce to access learning opportunities via the Department of Health's e-learning for End of Life Care project but should also ensure they access other classroom based education in end of life care. Group A and Group B staff in particular should have access to end of life care education that includes transformative learning methods.	69

No.	Recommendation	Page of strategy
28	Providers of end of life care education in South East London should ensure that their courses include both didactic and transformative learning methods.	69
29	Education commissioners in South East London should ensure that end of life care courses for at least staff Groups A and B include transformative learning methods.	69
30	Given the prevalence of end of life patient contact within the health and social care workforce and the importance of education in the provision of high quality end of life care, it is strongly recommended that: • For all staff employed by caring organisations there should be a mandatory session on end of life care during employment induction • Groups A and B staff groups have access to and complete mandatory training in end of life care relevant to their role and exposure to this work. For some Group A staff this is already established through requirements for academic qualifications in palliative care when following particular career pathways • For Groups A and B staff members, and as recommended within the national End of Life Care Strategy, this training should cover as a minimum the following subjects: communication skills, assessment and care planning, advance care planning and symptom management, as they relate to end of life care • Group C staff members should at least have access to induction programmes that include training regarding the principles of end of life care	69
31	Education commissioners and providers should consider options for the creation of 'train the trainer' programmes to provide delivery of basic palliative and end of life care education through cascade principles of training.	70
32	For staff that have significant or sole responsibility for end of life care as part of their role, provision of adequate training, development and mentorship for them by appropriate specialist practitioners should form an explicit part of the professional accountability of these posts, as part of their job description and contract.	71
33	Providers of end of life care education, health and social care service managers, and education commissioners should work together to develop programmes that include practice education. Such opportunities should in particular be made available for Group B categories of staff.	72
34	Providers of end of life care education should ensure that their education programmes include opportunities for interdisciplinary learning and that these courses include opportunities for team based clinical case analysis and learning.	73
35	Health and Social care service managers should encourage relevant members of their workforce to attend courses that have an interdisciplinary approach. This may involve allowing the release of complete teams from clinical work to attend such training.	73

No.	Recommendation	Page of strategy
36	Education commissioners in South East London should ensure that palliative and end of life care courses include opportunities for interdisciplinary learning.	73
37	Given the importance of raising standards in the quality of end of life care, commissioning plans should enable health and social care workers to receive appropriate end of life care education and training without having to self-fund.	79
38	When negotiating the commissioning of palliative and end of life care education programmes, commissioners and education providers should include the cost of backfill for clinicians acting as educators.	79
39	Specialist Palliative Care professionals should acknowledge their expertise and importance in the delivery of palliative and end of life care education to the generalist workforce, ensuring that this role is prioritised in their work planning.	79
40	Given the unfavourable findings relating to care home staff skills in end of life care provision as described the National Audit Office (NAO) *Report on End of Life Care* (2008), Primary Care Trusts should support with funding the care home proposals set out by the Marie Curie Delivering Choice Programme in conjunction with St Christopher's Hospice.	83
41	Education leads, commissioners and providers should ensure that opportunities to submit bids for additional CPPD funding are undertaken to enable an increase in access of their staff and staff from related services to end of life care education and training.	86
42	Education providers should have available fully costed education programmes, so that incidental funding opportunities can be actioned promptly	87
43	If options 1 or 2 adopted (p88) Education leads and commissioners within NHS organisations as well as education providers should ensure that the newly formed Education Commissioning Hub, if procuring palliative and end of life care education, engages with the full range of relevant education providers in South East London as indicated via the 2007-8 course mapping in section 3.4.2	90
44	If options 1 or 2 adopted (p88): If procuring palliative and end of life care education and training themselves, education leads and commissioners within NHS organisations should engage with the full range of relevant education providers in South East London (as indicated via the 2007-8 course mapping in section 3.4.2)	90
45	If options 3 or 4 adopted (p89): Although the alliances or individual PCTs may play some part in decision making regarding the commissioning of palliative and end of life care education and training, it remains more logical to focus this work at sector level and this should be the approach.	93

No.	Recommendation	Page of strategy
46	If options 3 or 4 adopted (p89): If palliative and end of life care education and training commissioning for South East London became the responsibility of SELACU, a reference group made up of clinicians and educationalists would be required to inform their decision making. The existing South East London Palliative and End of Life Care Coordinating Group, which is managed currently by the South East London Cancer Network, could provide this expertise.	93
47	If options 3 or 4 adopted (p89): The maintenance of an End of Life Care Clinical Network for South East London is strongly recommended since, as well as other components of commissioning such as workforce development and service quality measurement, palliative and end of life care education and training commissioning would be best approached at a sector level.	93
48	Primary Care Trusts in South East London should ensure that this funding (p94) is fully spent on optimising access for both health AND social care staff to palliative and end of life care education and training.	94
49	Social and health care provider organisations in both the statutory, voluntary and independent sectors should campaign for Primary Care Trusts to fully spend this funding on the provision of end of life care education and training for their staff.	94
50	Commissioners of care provision from independent sector social care agencies should include the cost of education in end of life care within procurement contracts.	96
51	Employers of staff not discussed in this strategy (including prison staff, staff working in housing departments, and other support staff outside of the NHS) should ensure they have access to funding for education and training to obtain this knowledge. Where appropriate, this education could be provided by other more senior staff within their organisation who had attended more advanced training.	96

OUR STRATEGIC AIM & VISION

Our overall strategic aim is two-fold:

1. to ensure that a full range of education and training related to the end of life care pathway is available across South East London to meet the needs of our health and social care workforce

2. to enable those responsible for end of life care education and training commissioning to procure comprehensively from a full range of education providers in a systematic and strategic manner.

This will then move us towards fulfilling our vision that:

All relevant health and social care staff in South East London will have the appropriate knowledge and skills to provide high quality palliative and end of life care.

BACKGROUND

Since its establishment following recommendations in the *NHS Cancer Plan* (2000), the South East London Cancer Network has hosted a flourishing Palliative Care and more recently also End of Life Care Network; successfully engaging stakeholders in service development and the implementation of national strategy. Strategic direction for this work has been coordinated via stakeholder and network collaboration in a sector-wide Palliative and End of Life Care Coordinating Group (PCCG). The Palliative and End of Life Care Network's current strategic aims include to create "a workforce development strategy in partnership with workforce development leads and Higher Education Institutions in SE London" (South East London Education Palliative & End of Life Care Strategy 2007-9).

The Marie Curie Delivering Choice (MCDC) Programme's first flagship project was launched in Lincolnshire in October 2004. The aim of this and subsequent programmes has been to help local providers and commissioners of care to develop the best possible services for palliative and end of life care patients regardless of diagnosis, so that end of life care patients can be cared for in their place of choice. In September 2007, South East London became the Programme's fifth site and the ensuing Phase I scoping of need led to the prioritisation of key work streams, which included 'Training, skills and development for health, social care and carers who provide care for palliative patients'.

At the commencement of the South East London MCDC Programme the work that underpins this strategy had already been started by a PCCG tasked sector-wide Education and Training working group. The achievements by this group include the mapping of palliative and end of life care education provision and preliminary discussions for the creation of a competency framework for generic and specialist palliative care clinical staff.

In December 2008, it was agreed that the end of life care education and training strategy for South East London would be developed by way of the MCDC education and training work stream.

CONTEXT AND DRIVERS OF CHANGE

1. THE NATIONAL CONTEXT- a motivation for change

1.1 The National End of Life Care Strategy and related initiatives

Until recently, end of life care has typically had a low profile within the NHS and has often been a low priority in terms of service improvement for both commissioners and providers. However, with the emphasis on end of life care as one of the eight clinical pathways developed by each of the Strategic Health Authorities in England as part of Lord Darzi's *NHS Next Stage Review* (2008), this situation is set to change. In July 2008, a national *End of Life Care Strategy* was published by the Department of Health in parallel with Lord Darzi's final report, adding momentum to this increase in profile for end of life care. As the title of the national strategy suggests, its aim is to promote high quality care for adults at the end of life and significantly the development of the end of life care workforce forms one of its eight chapters.

1.1.1 With regard to workforce development, the key messages within the *End of Life Care Strategy* are:

- *For a cultural shift in attitude and behaviour related to end of life care within the health and social care workforce*.
  In other words, death is inevitable and does not necessarily constitute a failure of care
- *For a focus on the resolution of the major deficiencies in the knowledge and skills of staff groups who come into frequent contact with people at the end of their lives, rather than on an expansion in the workforce*
- *That programmes to enhance training for medical undergraduate / postgraduate and other pre-registration students will take longer to demonstrate benefits for people approaching the end of life, but are of equal importance in the long-term*
- *That staff delivering any aspect of end of life care have a personal responsibility to ensure they have the necessary skills and competencies to enable them to deliver high quality end of life care.*

In addition, the *End of Life Care Strategy* outlines the broad programme of workforce development that needs to be instigated to ensure that all staff caring for people approaching the end of life have the necessary knowledge, skills and attitudes. It

identifies the key responsibilities for different aspects of this programme for professional regulators, providers of higher education, Strategic Health Authorities, employers, Skills for Health and Skills for Care, and e-Learning for Healthcare.

1.1.2. As pledged in the *End of Life Care Strategy* and with help from the Strategic Health Authority Pathway Chairs for the Darzi NHS Next Stage Review, the Department of Health has developed *Quality Markers and Measures for End of Life Care*. This document is aimed at commissioners, performance managers and providers of end of life care services, from the NHS, local authority, voluntary and independent sectors and seeks to generate a national approach to raising the quality of care for people at the end of life. The final version was published in June 2009 and can be found via: www.dh.gov.uk/en/Publicationsandstatistics/Publications

Operating within the usual devolved NHS system, these Quality Markers are not mandatory. However, they provide a useful tool for Primary Care Trusts to formulate their plans for end of life care, to influence the development of key performance indicators when commissioners are forming contracts with care providers, and to support the boards of individual commissioner and provider organisations when defining and tracking progress against their own action plans.

1.1.2.1. Quality markers and measures within this document that relate to education and training include[1]:

- **For Strategic Health Authorities** to demonstrate that:
  i. The utilisation of the Multi Professional Education and Training levy (MPET) budget is in line with the Department of Health's main expectations for the use of funding related to end of life care as set out in the annual service level agreement between the Department and Strategic Health Authorities

     ***Measure**:* The MPET investment plan sets out proposed levels of *training and development relating to end of life care*, and includes details of partnerships with commissioners, providers and assessors of services (including training providers) in determining *workforce development needs across health and social care*
  ii. *Training commissioned* for pre-registration and undergraduate students contains *curriculum content relating to end of life care*

[1] All points listed are extracts from 'Quality Markers & Measures for End of Life Care', 2009

iii. The *end of life care training needs of workers* (including those working in specialist palliative care services) within hospitals, community settings, care homes, hospices, ambulance services and other health and social care settings are incorporated into investment plans.

- **For Strategic Health Authorities and Primary Care Trusts** to ensure that training programmes are available and accessible to these workers and take into account the four *core common requirements for workforce development* (communication skills, assessment and care planning, advance care planning, and symptom management) as they apply to end of life care.

  Measure: Written evidence that *training programmes* relating to end of life care are available and accessible to *health and social care workers*.

- **For Primary Care Trusts** to demonstrate that:
  i. all providers have processes in place to ensure that discussions with individuals regarding end of life issues are undertaken by *appropriately trained* workers
  ii. all providers have processes in place to identify the *development needs* of all other workers (registered and unregistered, including volunteers) across *health and social care* who require *end of life care related training*, taking into account the four *core common requirements for workforce development* (as described above) as they apply to end of life care
  iii. *training investment plans* from providers are assessed in partnership with the Primary Care Trust and agreed with those responsible for workforce at Strategic Health Authority level
  iv. all providers are aware of *end of life care training* available, and enable relevant workers to access or attend *appropriate programmes* dependent on their needs.

  Measures:

  a. The local strategic plan encompasses a *workforce development and investment plan* that includes the development and training needs of GPs, hospital doctors, nurses, allied health professionals, ambulance staff, social workers, support workers, care home staff and others as appropriate to their local service.
  b. Documentary evidence of providers' *training investment plans*, including training and refresher courses.

c. Written evidence that the *training investment plans* have been agreed with the Strategic Health Authority.

- **For care providers** to:

  i. have processes in place to identify the *training needs* of their workers, taking into account the four *core common requirements* (as described previously) as they apply to end of life care.

  Examples of measures[2]:

  a. Documentation showing processes for determining training, needs and the *training investment plan*.
  b. Documentary evidence of workers who have received *training, including refresher courses*.
  c. *Availability of 'foundation' programmes in end of life care* for non-registered workers who may have to deal with patients approaching the end of life or just after death, or their families and carers.
  d. Number / proportion of workers attending such programmes.
  e. *Availability of educational programmes related to end of life care* for registered workers.
  f. Number/proportion of workers attending such programmes.

  ii. be aware of *end of life care training opportunities* (including training related to the Liverpool Care Pathway or equivalent) and enable relevant workers to access or attend appropriate programmes dependent on their needs.

- **For *all* care providers, including ambulance services** to take particular account of the *training needs* of those workers involved in discussing end of life issues with individuals and their families and carers.

  Measures:

  a. *Availability of training programmes* for workers involved in discussing end of life issues with patients and carers.
  b. Documentary evidence of workers who have received such training, including refresher courses.
  c. For ambulance services: Documentation showing processes for determining *training needs*, and a *training investment plan*.

[2] Within 'Quality Markers & Measures for End of Life Care', different care settings have different measures attached to this marker

- **For acute hospitals** to have effective mechanisms for identifying those who are approaching the end of life, including *availability of training* for front-line hospital clinicians in identification of patients approaching the end of life.

- **For out of hours community nursing and medical services** to have a workforce that is competent in providing general palliative care, including symptom management, the use of syringe drivers, assessment of the need, communication skills and providing support both to the patient and to carers in relation to 'Do-Not-Attempt-Resuscitation' and advance decisions.

  Measure: Documentary evidence of workers who *require training, have received training and who have attended training courses, including refresher courses.*

- **For community-based specialist palliative care teams** to act as an educational resource for the training of generalist palliative care in the community, including GP practices, district nursing services, care homes and community hospitals.

  Measure**:** Availability of a *strategic plan* for the *education* of community based providers of end of life care.

Recommendations:

As will be illustrated in section 3.4.2, *Mapping and analysis of current palliative and end of life courses for South East London***,** hospices and specialist palliative care teams / services based in acute hospitals also act as an educational resource for the training of generalist palliative care.

1. **There should be widespread acknowledgement that all Specialist Palliative Care Teams are and should be an educational resource for generalist end of life health and social care providers.**

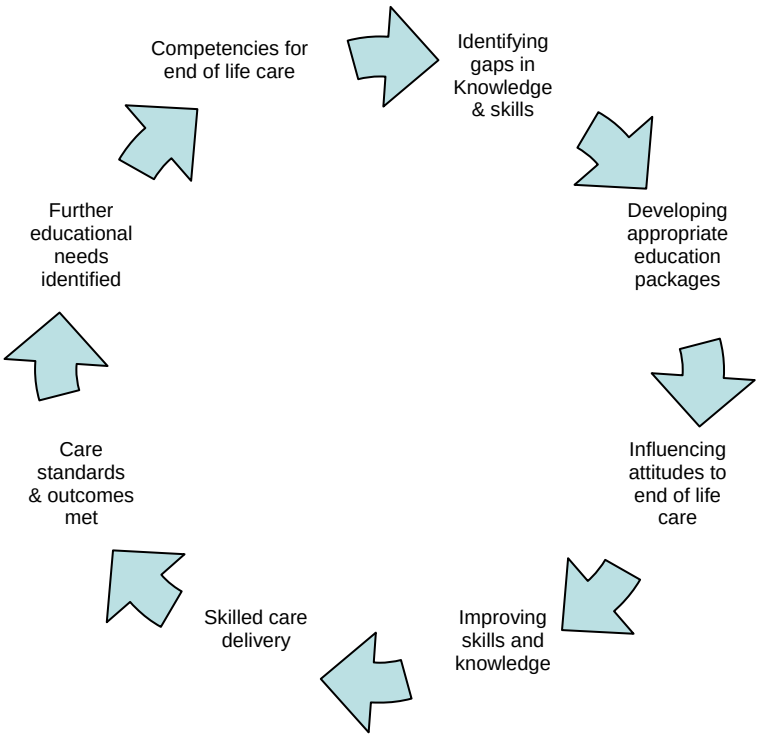
2. **Education commissioners and providers should aim to create and deliver education and training packages which allow staff from different settings to learn together**

3. **Primary Care Trusts and care providers within South East London should implement the Quality Markers and Measures that are relevant to them.**

4. **Primary Care Trusts and other relevant bodies should encourage NHS London to adopt the Quality Markers and Measures that are relevant to them.**

1.1.3 The national strategy acknowledges that one of the most pressing tasks has been to define the core principles and competencies required by each staff group when they deliver end of life care. As illustrated in figure one, agreeing and establishing competencies for care is vital to ensuring the correct steps are subsequently taken for the development of a skilled and knowledgeable workforce:

Figure 1: Cycle for skills and knowledge development



The Department of Health asked Skills for Health and Skills for Care to undertake this development and they did this in collaboration with the NHS End of Life Care Programme.

A draft version of the core principles and competencies, as well as 'common core requirements for End of Life Care linked to occupational standards and requirements' were released for consultation in early 2009. Evaluation of these competencies and

principles occurred at test sites across the United Kingdom, including South East London. This local testing was undertaken by the current *Modernisation Initiative Programme team,* a Guy's and St Thomas' Charity Project that presently seeks – with additional funding from the South London and Maudsley NHS Foundation Trust and King's College Hospital Charity – to improve end of life care within Lambeth and Southwark. This testing was achieved in collaboration with St Christopher's Hospice and other local organisations.

1.1.3.1 The final document, '*Common core competences and principles for health and social care workers working with adults at the end of life'* was launched in June 2009, with its main purpose to ensure that all health and social care workers are confident and able to work with people at the end of their lives. The document can be accessed via the national End of Life Care Programme website at: http://www.endoflifecare.nhs.uk

These competencies do not replace those occupation or service specific standards and competences already in place, but are designed to be used alongside these, ensuring that all services are tailored to meet the needs of people at the end of their lives. While individual workers will find this document helpful, it is also aimed at those planning or delivering education and workforce needs. Commissioners of end of life care services could also use it to assess whether the organisations they contract with have staff with the knowledge and skills needed to deliver high quality end of life care.

1.1.3.2 The document sets out and has detailed dimensions relating to four competency areas, namely:

- Communication skills
- Assessment and care planning
- Symptom management
- Advance Care Planning

The detailed dimensions relating to these competency areas can be found in appendix three.

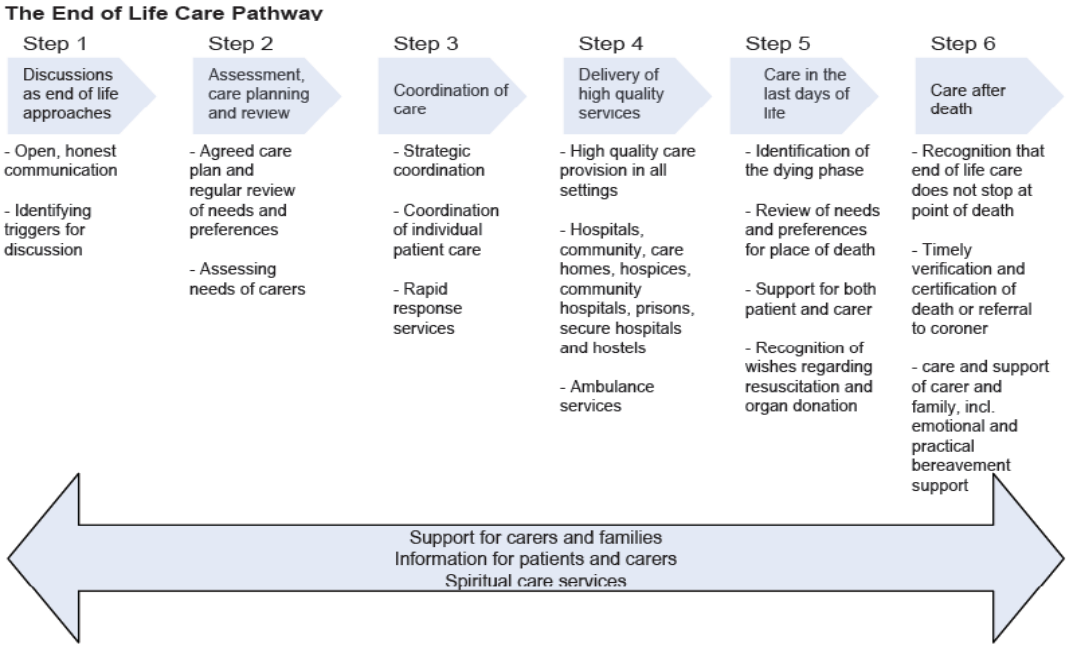
The document also suggests seven overarching principles that should be applied to these competency areas and describes these principles in detail. The overarching principles are:

- The choices and priorities of the individual are at the centre of all end of life care planning and delivery
- Effective, straightforward, sensitive and open communication between individuals, families, friends and workers underpins all planning and activity
- High quality end of life care is delivered through close multidisciplinary and inter-agency working
- Individuals, their families and friends are well informed about the range of options and resources available to them to enable them to be involved in the planning, developing and evaluating of end of life care plans and services
- Care is delivered in a sensitive, person-centred way that takes account of the circumstances, wishes and priorities of the individual, their family and friends
- Care and support are available to, and continue for, anyone affected by the end of life, and death, of the individual
- Workers are supported to develop knowledge, skills and attitudes that enable them to initiate and deliver high quality end of life care or, where appropriate, to seek advice and guidance from other colleagues. Workers recognise the importance of their continuing professional development, and take responsibility for it.

The document includes summary case studies from the pilot sites to illustrate how the core competencies and principles can be applied in practice and to describe any lessons learnt through this testing.

1.1.3.3 The national *End of Life Care Strategy* suggests that consideration should be given as to how these four competency areas are broken down to reflect the knowledge, skills and attitudes required to undertake each of the roles described within the end of life care pathway, as illustrated in figure two:

Figure 2: The End of Life Care Pathway



Source: End of Life Care Strategy: Promoting high quality care for all adults at the end of life (July 2008)

Please note that this pathway includes and the end of life care strategy recommends the use of the three nationally recognised End of Life Care tools:

- The Gold Standards Framework, currently for primary care and care home settings and a method to ensure good coordination of multidisciplinary team care for end of life care patients
- The Preferred Priorities for Care tool or similar advance care planning tool, to enable documentation of patients' preferences and choices
- The Liverpool Care Pathway, to facilitate appropriate good care in the last days of life.

1.1.3.4 The document, '*Common core competences and principles for health and social care workers working with adults at the end of life*,' sets out a clear implementation plan, with the NHS End of Life Care Programme team intending further work between July 2009 and March 2010 to:

- raise awareness of the document across health and social care utilising appropriate media
- promote and provide support to organisations and individuals in using the competences and principles in workforce management

- link the competencies and principles with recognised occupational standards and levels of development, e.g. Knowledge Skills Framework (KSF) and Qualifications and Credit Framework (QCF) plus others as appropriate
- work with medical Royal Colleges/Association of Palliative Medicine and other health and social care professional bodies to ensure compatibility and consistency of approach across medical and non-medical workforce development
- identify and develop additional related competences relating to the end of life care pathway, e.g. spirituality and well-being, care after death, support for workers
- review uptake and application of competences as part of an ongoing review and update cycle

Recommendations:

5. **All individual health and social care workers in South East London should be supported to determine their education and training needs in end of life care by referring to these core competencies and principles**

6. **All relevant health and social service managers in South East London should determine the education and training needs in end of life care of their staff by referring to these core competencies and principles**

7. **All South East London organisations that deliver end of life care education and training should refer to these core competencies and principles when determining educational programmes, course curricula, outcomes and in designing course material. They should ensure that their courses cover the knowledge, skills and attitudes required for health and social care staff to deliver all aspects of this pathway of care.**

8. **Education commissioners in South East London should ensure that there is access to a full range of end of life care education and training courses, in line with core competency requirements and the knowledge and skills needed to deliver the end of life care pathway.**

1.1.4 The Department of Health's *e-learning for End of Life Care project* (ELCA) is designed to support the implementation of the workforce development aims within the national *End of Life Care Strategy*.

The project will deliver accessible, easily digestible e-learning materials for the four core competency areas identified in the *End of Life Care Strategy* and as described in section 1.1.3. Namely; communication skills, assessment and care planning, symptom management, and advance care planning.

These sessions are intended to complement and support a variety of learning experiences, including experiential and face-to-face learning. They enable those who are new to this area of care giving to gain some basic knowledge, encouraging them to take this further, whilst others can build on prior learning.

The programme will consist of approximately 180 e-learning sessions, all written by subject matter specialists and experts in their particular field and extensively peer reviewed. Each session will be around 20 minutes in length and will incorporate self-assessment tools, audio and video clips, and case studies. A whole module will be devoted to presenting the learner with a variety of clinical scenarios, drawn from real-life situations, to integrate and consolidate learning.

It is anticipated that all health and social care workers plus those in the voluntary sector will be able to access ELCA via the e-Learning for Healthcare website at http://www.e-lfh.org.uk by January 2010.

1.1.5 In early 2009 the National Council for Palliative Care (NCPC) launched a major new training initiative: *Care to Learn - the NCPC End of Life Care Training Programme,* which is available for purchase as a pack designed to be delivered in the workplace in a flexible and practical format that fits staff and organisational needs. It promotes its key benefits as:

- Delivers introductory end of life care training for staff in all settings
- Offers eight modules that staff can complete in their own time and at their own pace, in groups or individually
- Follows the End of Life Care Pathway, from 'Starting the Conversation' through to 'Care after Death', including support for carers and the Mental Capacity Act

- Each pack contains a training booklet, work book and mentor's guidance booklet, which are yours to keep within the workplace for future use

Further information can be found at http://www.ncpc.org.uk

1.1.6 Macmillan Cancer Support provides the following free web-based education resources:

- An *Out of Hours Toolkit* for GPs, nurses and other professionals which includes information on symptom control, practical aspects of care at the end of life, palliative care emergencies etc.
- *Supporting your Service (through learning & development)* - a resource for support workers with bite-size lessons including Loss & Bereavement, Dealing with difficult situations, and Listening & Responding.
- A *Sexual Relationship Toolkit* which includes "Sex at the end of life" on power point slides
- *Foundations in Palliative Care,* a learning package produced in conjunction with the Open University for use by support workers, particularly in care homes

These resources can be found at http://learnzone.macmillan.org.uk

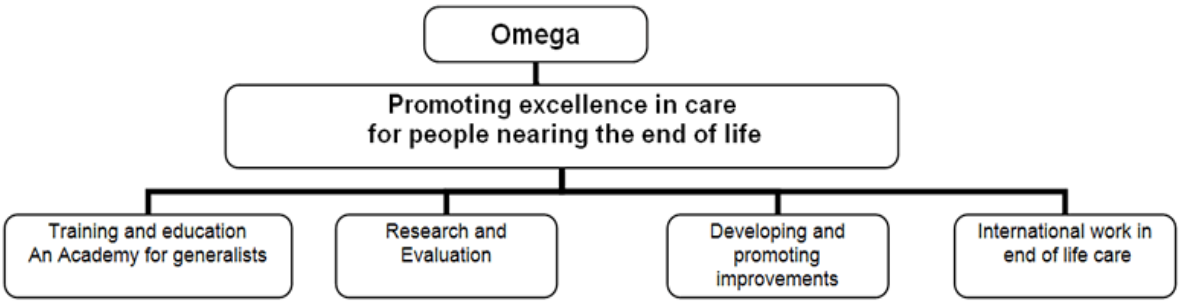
1.1.7 In support of a priority set out for workforce development within the *End of Life Care Strategy*, the National End of Life Care Programme in partnership with *Connected* (the Advanced communication skills training team based within the National Cancer Action Team) called for expressions of interest from cancer networks, Primary Care Trusts, and Local Authorities to be involved in developing all levels of communication skills training for the health and social care workforce. This will include testing out approaches to the planning, development and delivery of such training. Their intention is that:

- the benefits of existing advanced communication skills training for senior cancer clinicians can be extended to other senior clinicians working with end of life care patients
- there is the development of a national framework for the delivery of both basic and intermediate level communication skills training for all health and social care staff members providing end of life care

Following a successful bid, South East London in collaboration with the North East London Cancer Network, has been chosen as one of the pilot sites for this one-year programme of work. The project will run between June 2009 and autumn 2010. The aims of this pilot are:

- to benchmark existing communication skills training at basic and intermediate levels and develop an education specification for these courses to enable their ongoing commissioning
- to recruit and train additional advanced communication skills training facilitators and then evaluate delivery of courses by them to senior members of the end of life care workforce.

1.1.8 *Omega*, the National Association for End of Life Care, is a newly formed charity aiming to promote excellence in care for people nearing the end of their lives. It developed from and is closely aligned with the work of the National Gold Standards Framework Centre, but has a larger remit in end of life care, covering four areas of work:



Their *Academy for Generalists in End of Life Care* will deliver quality training to health and social care providers who do not specialise in palliative and end of life care. With their partners at the National Gold Standards Framework Centre they aim to run training programmes across the United Kingdom.

Within this Academy they will also include training for non-paid carers of end of life patients, namely relatives, friends and others.

Information about this can be found on their website at www.omega.uk.net

1.2 Other national drivers

1.2.1 **The National Audit Office (NAO) *Report on End of Life Care*** was published in November 2008 and considers the scope for improving the pattern of end of life care in light of the available evidence on the impact and the appropriateness of existing provision. The evidence within the report is drawn from the knowledge and experiences of a wide range of health and social care staff involved in the delivery of end of life care and, most importantly, people approaching the end of their life and those caring for them. The findings relating to the education and training needs of the end of life care workforce can be seen in the following section.

1.2.1.1 The NAO survey highlighted a lack of training in end of life care for doctors and nurses, in particular during pre-registration courses. Doctors and nurses were nevertheless fairly confident in their abilities when asked to rate their confidence in identifying, delivering and communicating about end of life care. However, amongst generalist doctors, GPs ranked their confidence lowest in identifying the point when end of life care should begin; cardiologists were least confident in the delivery of end of life care; and emergency / intensive care specialists were least confident in discussing end of life care. Sixty-eight per cent of neurology nurses expressed the need for palliative care training.

Primary Care Trusts (PCT) were found to rate education and training for care home staff as the biggest challenge to providing good quality end of life care. Care homes rated their skills and abilities more highly than the ratings given them by the hospice and specialist palliative care teams working with them – who raised concerns about the nature and quality of the training the care homes are accessing. End of life care training in care homes is patchy and not mandatory, with only 5% of care home workers possessing NVQ level 3 qualifications.

The report identifies examples of specialist palliative care providers working with generalist staff to increase competence, confidence and capacity. A third of independent hospices alone provided training to 18,000 external staff in 2006-07, including some from care homes. Detailed PCT reviews identified examples of hospices providing outreach training in care homes, doctors' surgeries, community hospitals and other care settings.

Fifty-four per cent of general nurses and a third of doctors reported being trained in the use of at least one of the three national end of life care tools (Gold Standards

Framework, Preferred Priorities of Care, Liverpool Care Pathway). This compares to 91 per cent of nurses and 95 per cent of doctors specialising in palliative care.

1.2.2 In 2000 the first national training strategy report on ***Modernising the Social Care Workforce*** concluded that the domiciliary care workforce received little attention regarding education and training, despite the fact that the majority of front line care is provided by this group (Ian Rees, Regional Development and Standards Officer, TOPSS England October, 1999**)**. This is a large and diverse workforce, many of whom work part-time and about which there is little information. What is known is that, unlike the majority of the other members of the health and social care workforce, most of these staff have little or no access to substantial training and have no formal qualification.

1.2.2.1 The General Social Care Council (GSCC), the social care workforce regulator in England for both adults' and children's services was established under the Care Standards Act 2000 and opened its register in 2003. Significant progress has been made in setting clear professional standards for social workers in England since 2000. All social workers and social work students are now required to be registered with the GSCC which helps to assure public safety and to drive up professional standards by:

- setting standards which a social worker must meet
- setting standards of conduct and minimum standards for continuing professional development which a social worker must achieve in order to remain on the register
- providing a mechanism to take action against unacceptable standards of conduct on the part of social workers by operating systems to investigate complaints made by members of the public or employers about the practice of individual social workers
- quality assuring the provision of social work education and training to ensure that it meets minimum standards (set by the GSCC).

1.2.2.1.1 In 2007 the Government announced that home care workers would be the next group of social care workers to be registered. Since then the GSCC has been working up detailed proposals. This register is expected in early 2010, initially on a voluntary basis with the expectation that registration would be made a compulsory

requirement thereafter. The GSCC is expected to consult on proposals for the registration of personal assistants in due course.

Recommendations:

9. **Education commissioners and providers should ensure education and training in palliative and end of life care is available to domiciliary care workers as a priority**

10. **Primary Care Trusts and local authorities should ensure that, when commissioning care packages for people in need of end of life care, the care agency guarantees its workers have the necessary knowledge, skills and attitudes to do the job. This requirement should be made explicit within contracts**

11. **Where care packages are sub-contracted to independent provider organisations their workers should also have accessed relevant end of life care training packages from local expert education and training providers**

12. **Local authority and independent domiciliary care agencies should ensure their staff have received appropriate training in end of life care**

13. **Smaller domiciliary care employers should receive support in understanding the educational needs of their staff and how they can find appropriate end of life care development and training. This might be achieved through dialogues between service commissioners and the service agency in their contracting process.**

1.3 Although not specifically concerned with the education and training of the health and social care workforce in relation to end of life care, the following key national strategies and guidance documents for workforce development are acknowledged as influencing the remit of this strategy for South East London:

- *Working to Put People First*: The Strategy for the Adult Social Care Workforce in England, 2009
- *Modernising Medical Careers: Third Report of Session 2007–08*, House of Lords Health Committee, 2008
- *Modernising Nursing Careers: Setting the Direction*, Department of Health, 2006

2. THE PAN-LONDON CONTEXT- creating opportunities for change

2.1 For London, the delivery of Darzi's end of life care recommendations is being driven by Healthcare for London in partnership with Primary Care Trusts and NHS London. The Healthcare for London End of Life Care Project is currently likely to include the development of educational packages related to end of life care. A facet of its activity will be to work with two pan-London healthcare systems as pilot sites for service improvement. Part of the intention of this work is to create a shift in attitudes and practice in the acute sector to support the identification of patients who are dying.

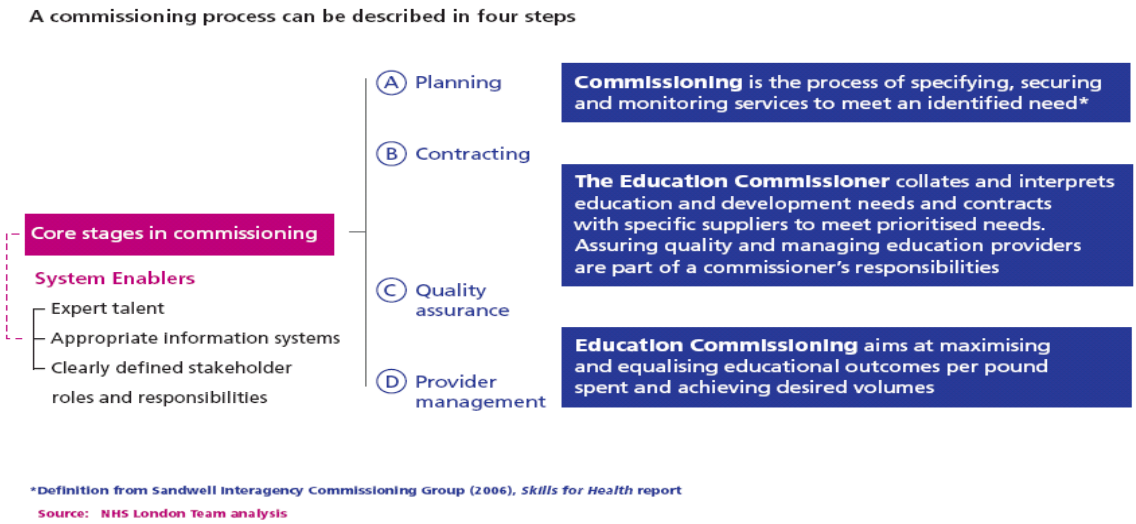
2.2 In September 2008 NHS London launched *'Workforce for London - a Strategic Framework'*, London's first ten-year vision for its healthcare workforce. The framework is the result of extensive discussions and work with stakeholders to consider the workforce changes and developments needed to deliver the vision from Lord Darzi's *NHS Next Stage Review Final Report* (2008) as set out in Healthcare for London's vision of "world-class healthcare for every Londoner which is responsive, safe, accessible and of a very high quality".

2.2.1 Within this framework, and through diagnostic work undertaken in 2007, NHS London has identified the current system for planning, educating, developing and deploying staff as unfit for purpose. Key challenges include:

- Workforce planning and education commissioning is not currently integrated with health and social care service planning and strategic commissioning intentions
- Education investment is not adequately aligned to service need and future development
- There is a lack of transparency and accountability for both effective workforce planning and education commissioning
- Educational outcomes are often of variable quality and fail to meet the needs of employers
- There are insufficient incentives to support the development of innovation and choice, and to reward excellence in education
- There is a lack of capacity and capability throughout the system to develop robust integrated workforce plans and there is a need to strengthen the education commissioning programme

2.2.2 The proposed solution to these challenges is to develop a new approach to workforce planning and education commissioning via the principles advocated in world-class commissioning, as illustrated in figure three:

Figure 3: Education Commissioning Process



2.2.3 The broad measures within *the Workforce for London Strategic Framework* that are relevant to this South East London end of life care education strategy are :

Workforce planning

- In partnership with stakeholders across London, to develop a new approach to workforce and education planning
- For workforce and education planning to be based on service planning
- By supporting the development of the necessary infrastructure, for planning to take place locally wherever possible and London-wide only where necessary
- For planning to be based on better information with greater transparency of outcomes, value for money and quality, thereby stimulating innovation and choice, rewarding excellence and intervening where necessary

Clearer processes

- To create a new education commissioning regime which will lead to better investment decisions; with greater transparency and accountability; creating a clear distinction between the roles of those who commission education and those who provide it

Greater accountability

- Ensure greater accountability for the quality of the education provided through the introduction of new contractual frameworks - redefining productivity and quality metrics, drawing on national arrangements and recognising and rewarding notable achievement
- Create a London Workforce Intelligence Unit to provide the analytical oversight to the system and support better, higher quality procurement of education at all levels via a London-wide education commissioning hub

More flexibility

- To create freedom for education providers to innovate and offer a wider range of education programmes
- To support better local decision making by devolving, where possible, education investment decisions
- To allow money to follow the student, rewarding the best and most effective providers and creating real incentives for both NHS and HEI education providers across London to continuously improve their education programmes
- With the move from hospital to community-based care, develop a London-wide plan for the medical workforce with a new focus on training in community settings; ensuring that doctors working in new ways and in different environments are targeted through education and training and also providing the necessary investment to allow education and medical training to be delivered in these new settings at both undergraduate and postgraduate level

More involvement for employers

- Provide a stronger voice and control in commissioning decisions for employers on both the content and outcomes of education based on improved access to better information

Stronger partnerships

- Develop strong and constructive partnerships with new professional advisory bodies pan-London and nationally, including Medical Education London.
- Actively encourage and support the introduction of Academic Health Sciences Centres (AHSCs) and Health Innovation and Education Clusters

(HIECs) across London; bringing health, higher education, research and industry together

Targeted funding

- Generally develop excellence in education through targeting investment both in community settings and specialist centres, therefore also investing in the development of primary care education centres
- Provide dedicated funding to Healthcare for London Care Pathway Groups to develop tailored workforce strategies to support the introduction of new care pathways across London
- Encourage innovation by creating a dedicated fund to sponsor employers and education providers to cooperate in the creation of innovative programmes aimed at new roles and different models of care
- Commit to provide a minimum of 20% additional Continuing Personal and Professional Development investment, year-on-year, to underwrite the development of new skills and also to support the transformation of the London Ambulance Service workforce
- Focus on increasing the stability of London's workforce and promote employment opportunities by targeting education investment on non-professionally registered staff

During early 2009 NHS London began work with stakeholders to develop detailed plans for investment and implementation of all of the above intentions.

3. THE CONTEXT WITHIN SOUTH EAST LONDON – Scoping the current situation

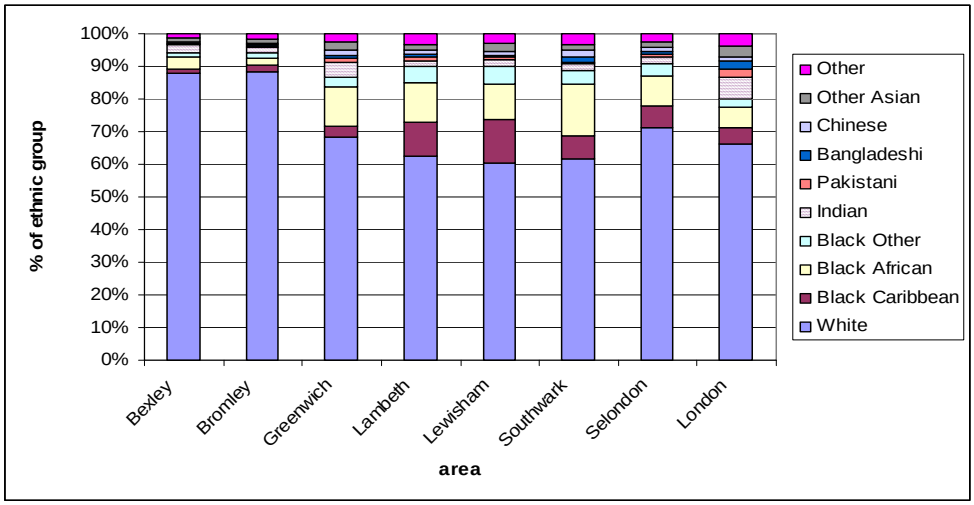
3.1 Relevant demographics in South East London

3.1.1 South East London is made up of the six London boroughs of Bexley, Bromley, Greenwich, Lewisham, Lambeth and Southwark. It has a population of 1,568,000 people; males accounting for 49% and females 51% (GLA 2008).

Figure 4: Map of London highlighting South East London and its boroughs

3.1.2 In terms of what constitutes a good death, thinking can vary considerably between cultures (and individuals within a culture), raising the risk of misunderstanding and cultural insensitivity within care giving. Acknowledging the ethnic diversity of the population of South East London is therefore important within the context of a strategy to improve the skills and knowledge of the end of life care workforce. With more detail provided in figure five, South East London has a diverse population, with 71% White and 29% from a Black or ethnic minority background.

Figure 5: SE London ethnic composition, percentage, boroughs and London, 2008



Despite concerted effort it has not been possible to obtain ethnicity data for the whole health and social care workforce. Although the ethnicity of the population of South East London is diverse, it cannot be assumed that this workforce has a similar ethnic profile.

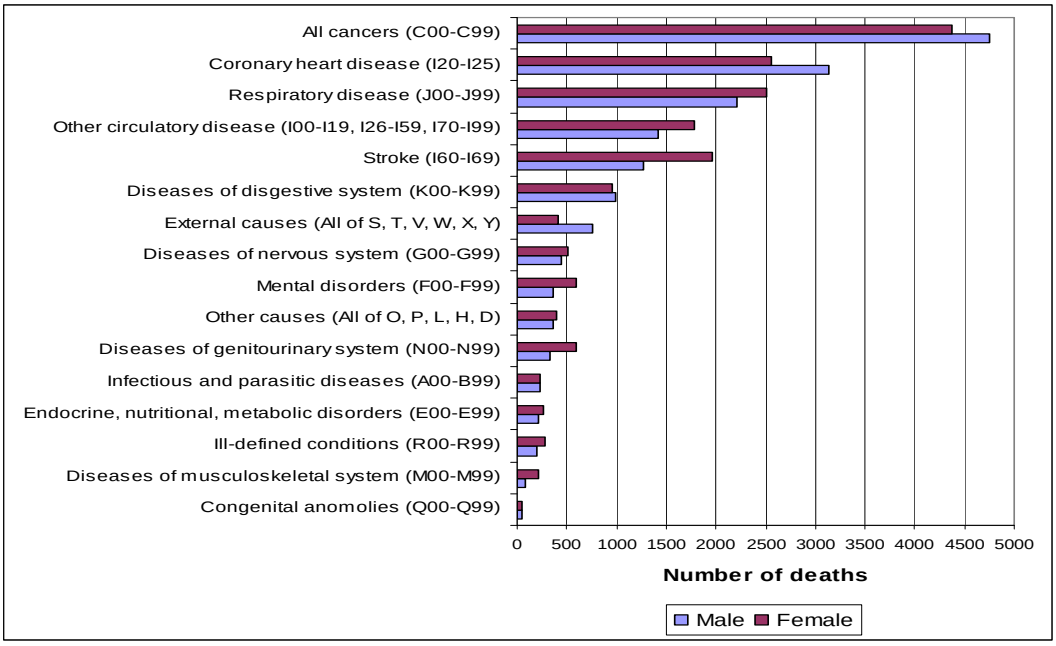
Recommendation:

14. To ensure that local health and social care services are delivering culturally sensitive end of life care relevant to local populations, the emphasis within education programmes should be for practitioners to ask end of life care patients their preferences, regarding their cultural and other needs.

3.1.3 Between 2004 and 2006 there were 16,805 deaths in males and 17,693 deaths in females of all ages across South East London. Although an undefined number of these will be deaths in childhood, it is expected that the majority will reflect deaths in adulthood.

As can be seen in figure six, the largest causes of deaths were cancer, respiratory diseases and circulatory diseases particularly coronary heart disease and stroke for both males and females. This is similar to the main causes of death in England.

Figure 6: Deaths by cause, South East London, numbers, 2004-06



Source: ONS, analysis by LHO

3.1.4. As illustrated in table one, the distribution of place of death per setting in South East London is similar to the average figures for the United Kingdom. These statistics illustrate that care in the last days and weeks of life can occur in any health and social care setting; meaning that a diverse range of workforce are exposed to the provision of end of life care and should therefore have access to appropriate end of life care education and training.

Table 1: Place of death in SE London, by percentage per setting, ONS, 2007

	SE London 2007	UK 2007 (Office of National Statistics)
Hospital	61.3%	58%
Home	18.7%	18%
Care Home Nursing	6.9%	17%
Care Home	4.2%	
Hospice	6%	4%
Other	2.9%	3%

Research suggests that the majority of people (between 56 and 74 per cent) express a preference to die at home. Although this proportion may decline as death becomes more imminent and people want access to more extensive support, the percentages shown in table one do illustrate that these preferences are far from being achieved. With the national End of Life Care Strategy making recommendations that should

allow more end of life care patients to die in their place of choice, implementation of the strategy could lead to professionals working in the community setting having the greatest need for education and training related to end of life care.

3.1.5 Over the last 20 years, although the population of England and Wales has grown, the total number of deaths per annum has declined. Current projections by Gomes and Higginson (2008) predict that the number of deaths will continue to fall until 2012 and thereafter there is likely to be a steady increase in the number of deaths. There are expected to be nearly 590,000 deaths per year by 2030; 16.5% more than in 2012. Also by 2030, it is predicted that the annual number of deaths in England in the over 85s will have increased from the current rate of around a third to 44 per cent.

With similar trends likely to occur for South East London, the effective training of the health and social care workforce in end of life care will become increasingly important.

3.2 The SE London Workforce - Beginning to establish numbers and needs

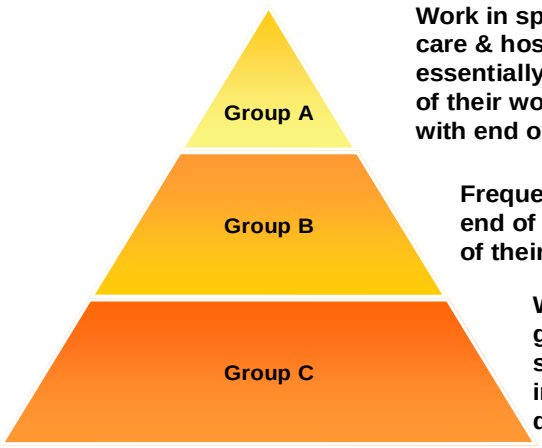
3.2.1 The national *End of Life Care Strategy* acknowledges that the workforce involved in end of life care is very large, consisting of both health and social care staff working in a variety of settings including the community, hospitals, care homes, hospices and other settings. They are employed by many different employers including the NHS, Local Authority, voluntary sector, charities, and a range of private health and social care providers. This workforce is also diverse and includes doctors, nurses, physiotherapists, occupational therapists, dietitians, speech and language therapists, social workers, chaplains, pharmacists, psychological support staff, ambulance staff and complementary therapists. Of these, the specialist palliative care workforce is relatively small (~5,500 nationally) compared to the total number of health and social care professionals who deliver end of life care, which is huge. Support staff can also frequently be exposed to work that involves meeting people with life-limiting illnesses, including caterers, porters, mortuary staff, housekeepers, drivers, grounds men, administrators, and fundraising staff.

3.2.2 Such a diverse end of life care workforce has the potential to create difficulties in developing an end of life care education and training strategy that can meet all of their needs and avoid too much complexity. The solution proposed within the national *End of Life Care Strategy* is to segment this workforce into three groups, as

illustrated in figure 7 below and with suggested minimum levels of skills and knowledge.

Recommendation:

15. **Employers should refer to this framework in determining which level of skill and knowledge a particular employee should attain.**



Work in specialist palliative care & hospices who essentially spend the whole of their working lives dealing with end of life care

Frequently deal with end of life care as part of their role

Work as specialists or generalists within other services who infrequently have to deal with end of life care

Group A: Physicians in palliative medicine, palliative care nurse specialist & allied health professionals, hospice pharmacists, senior palliative care

Group B: Secondary care staff working in A&E, acute medicine, care of the elderly, cardiology, oncology, renal medicine, long term neurological conditions, intensive care, hospital chaplains & some surgical specialities.
Primary care staff including GPs, District Nurses, community matrons, some care home staff, ambulance staff & some community based carers.
Specialist nurses, such as heart failure, HIV, cancer and other specialist nurses, based in primary or secondary care.
Community pharmacists

Group C: Other professionals working in secondary care or in the community; for example, care home staff and extra care housing staff, day centre & social care staff not involved in hospices, as well as domiciliary care & prison

Minimum levels of skills & knowledge

All staff should have the highest level of knowledge, skills and understanding through specialist training as part of further specialist registration and/or continuing professional development (CPD)

These should include communication skills, assessment, advance care planning, and symptom management as they relate to end of life care.

Minimum levels of skills & knowledge

Staff will need to be supported to enable them to develop or apply existing skills and knowledge to end of life care through CPD, or further specialist training and overcome any personal or team barriers.

This group has the greatest potential training need, in particular secondary care doctors (and their immediate teams), GPs (and teams) and District Nurses, who may be key in the 'trigger' discussion at the start of the pathway and with ongoing continuity of care.

These should include communication skills, assessment, advance care planning, and symptom management as they relate to end of life care

Minimum levels of skills & knowledge

This group must have a good basic grounding in the principles and practice of end of life care and be enabled to know when to refer or seek expert advice or information.

Many of the staff within care home settings and providing domiciliary care in this group have significant unmet training needs, including access to induction programmes.

Figure 7: Workforce Groups; Adapted from information in the national End of Life Care Strategy, 2008

3.2.3 To inform this strategy, investigative work was undertaken to establish the size of the workforce that delivers end of life care for South East London and therefore begin to determine the numbers of staff within Groups A-C that would require access to end of life care training. This was a difficult undertaking as data needed to be gathered from a number of sources, illustrating the complexity of the end of life care workforce. For various reasons, it was difficult to determine accurate workforce figures from the available data. This included that:

- Where workforce numbers are described in terms of full time equivalent posts, this has prevented an actual head count
- Some staff counted in the survey for Specialist Palliative Care will also be counted in the surveys for NHS or Local Authority employed staff
- Apart from the data for staff employed by local authority, the workforce data does not provide the numbers of the health and social care employed staff that provide support services, e.g. porters, drivers, caterers, etc. It also does not account for agency staff or those employed as Marie Curie nurses.

Overall, the following description of workforce data provides a good indication of workforce numbers for South East London, rather than a totally accurate head count.

3.2.4 Group A staff consists of the specialist palliative workforce. These data were easily obtained from an annual survey undertaken by the NHS Information Centre for Health and Social Care, the National Council for Palliative Care and the NHS Workforce Review Team and the latest version for 2007 can be seen in detail in appendix four.

Since there is no indication of whether all organisations providing Specialist Palliative Care submitted data, it is not clear whether the data provided is truly representative of the whole of this workforce for South East London. Certainly, for example, the suggestion that there are 2.2 full time equivalent (FTE) Palliative Medicine Consultants for the sector demonstrates an area of inaccuracy, as it is known that there are more of these doctors working in this role to cover the 10 community and 7 hospital based Specialist Palliative Care multidisciplinary teams and 3 Specialist Palliative Care inpatient units across South East London. Table two outlines the suggested Specialist Palliative Care workforce numbers for South East London in 2007:

Table 2: Specialist Palliative Care workforce numbers for SE London, as indicated in the 2007 survey

Post and / or Salary banding	Full time equivalent	Estimated head count
Nurses- Band 8	18.5	23
Nurses- Band 7	67	83
Nurses- Bands 5 / 6	54.6	67
Nurses- Band 2 / 3 / 4	37.2	46
AHPs- Psychological support staff	6	-
AHPs- Spiritual Support staff	1.4	-
AHPS- Complementary therapists	2.6	-
AHPs- Therapists	7.1	-
AHPs- Pharmacists	1.4	-
MDT Coordinators	1	-
Social workers	8.9	-
Others	2.2	-
Doctors- Consultants	2.2	-
Doctors- SpRs, registrars, StRs	3.8	-

3.2.5 Other surveys of workforce tend to be conducted by employer type; i.e. NHS staff, local authority staff, and care staff in the private and voluntary sector. As both Group B and Group C staff clusters work within each of these organisations and the headcounts or FTE are provided in this data by broad professional groupings only, for most professional groupings it is generally impossible to identify the workforce numbers for Group A and Group B staff clusters separately.

3.2.6 Data gathered by the NHS Information Centre for Health and Care provides a head count of NHS clinical staff. The figures for South East London at 30 September 2007 can be seen in full in appendix five and reveals that the sector has **44,847** staff from a diverse range of professional groupings. Table three provides a breakdown of

numbers of these staff. In addition there are **4,080** London Ambulance Service staff members working across the *whole of London*.

Table 3: Head count of NHS employed staff in SE London, September 2007

<table>
<tr><th colspan="5">Breakdown by Care Setting</th></tr>
<tr><th>Hospital Based Staff</th><th colspan="2">Mental health trust staff</th><th colspan="2">Primary Care Trusts (PCT)</th></tr>
<tr><td>25,849</td><td colspan="2">8,658</td><td colspan="2">10,340</td></tr>
<tr><td colspan="5"></td></tr>
<tr><th colspan="5">Break down by professional grouping (including care setting sub grouping where available)</th></tr>
<tr><td>Qualified nursing, midwifery or health visiting staff [A]</td><td colspan="3">Doctors [B]</td><td>Healthcare Assistants</td><td>Qualified allied health professionals</td></tr>
<tr><td rowspan="3">14.662</td><td colspan="3">5,541</td><td rowspan="3">5,692</td><td rowspan="3">2,145</td></tr>
<tr><td>Acute</td><td>Mental Health Trust</td><td>PCT</td></tr>
<tr><td>3,621</td><td>611</td><td>1,309</td></tr>
</table>

A: **1,026** are registered midwives and would be within the Group C cluster

B: **1,501** are Consultants working across all care settings, though an unspecified number of these; e.g. Directors of Public Health & Consultant Microbiologists, who will not have a clinical function

These figures provide workforce numbers for Group B and C staff working as NHS employees. However, it is important to note that the data relating to Specialist Palliative Care staff, as in section 3.2.4, identifies that there are 32.5 FTE registered nurses, 1.5 FTE counsellors, 0.6 FTE 'other staff', and 3.2 FTE social workers working within specialist palliative care who are NHS employees. Although it is not clear what these full-time equivalent figures translate into as a headcount, as Group A staff, these staff members should be deducted from the overall headcount for NHS staff who can be classified as a Group B and Group C mix.

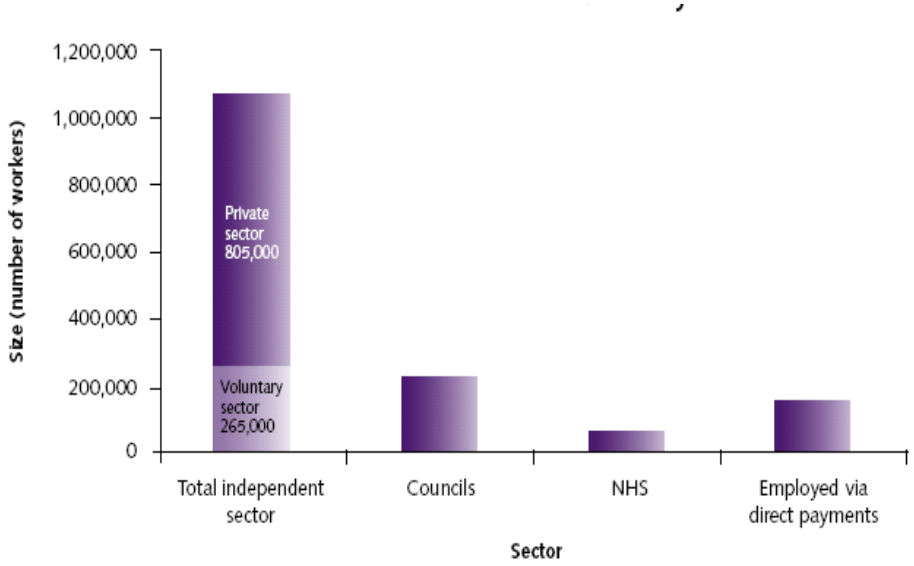
An unspecified number of this NHS workforce will provide care for children only, and will therefore not be subject to any of the recommendations within this strategy which is aimed at the education needs of the workforce providing care to adults facing death and dying.

Recommendation*:*

16. **These figures give an indication of the number of NHS staff in South East London who would require either Group B or Group C minimum levels of training. It is likely that the majority of this workforce would correspond to the Group C staff clusters. However, this can only be determined at an organisational level and, in line with the information in figure seven, relevant minimal levels of training regarding end of life care should be incorporated into the Knowledge and Skills frameworks for individual posts and then access by the worker to relevant courses enabled.**

3.2.7 The boundary of the social care workforce is not easy to define, but broadly it encompasses those who work in public services that are provided, directly or commissioned, by local councils to discharge their personal social services responsibilities. This definition is breaking down, as the boundaries of the organisations that provide personal social services shift (care trusts, integrated mental health services, etc). The workforce is highly diverse, reaching across the private, voluntary and statutory sectors and involving people working in a variety of different roles such as social workers, residential, day, and home care workers, personal assistants, and occupational therapists. The majority of social care service provision takes place outside the statutory sector through independent agencies. This is illustrated in figure eight which provides a comparison of the size of the national social care workforce by employment sector:

Figure 8: Estimated size of national social care workforce, by employment sector, 2007- 8



Source: The state of social care in England 2007–08 – Commission for Social Care Inspectorate (CSCI)

With over two-thirds of the social care workforce working in the private and third sectors, 60% of their 35,000 (estimated) employers nationally are classified as micro (having fewer than 10 employees) and a further 30% small (fewer than 50). Any strategy that seeks to make a significant impact on the quality of care provided by this workforce must therefore recognise the challenge of ensuring these small-scale employers appropriately train their employees in end of life care

In addition, the current movement towards the introduction of personal budgets for care provision means that more people using services may chose to employ professional care directly. While NHS and local authority professionals will hopefully be able to guide patients and carers to employ care staff / teams with the correct skills to meet their needs, this 'open-market' will create additional challenges in ensuring all social care staff dealing with end of life patients are supported and developed to do their job well.

Recommendations*:*

17. **Organisations in South East London, such as Primary Care Trusts, who commission care from private care agencies and care homes for adult patients who may develop a need for end of life care, should require from them an appropriately trained workforce in end of life care.**

18. Independent sector organisations and teams providing care to end of life care patients in South East London should ensure their staff have access to and undertake appropriate training and providing them with the minimum level of knowledge and skills for their role.

3.2.7.1 Data gathered in September 2007 by the NHS Information Centre for Health and Care provides a head count of social care staff employed by local authorities (appendix six). These data are comprehensive and include staff members who are unlikely to work directly with adult members of the public that will require end of life care, e.g. strategic staff / managers and technical officers. However, although included within appendix six, these staff numbers were easily removed from the figures provided below in table four to inform this strategy.

Unlike NHS employed workers, some of the staff listed within these data as providing care for children have been included in the figures given below for the 'adult' end of life care workforce in the South East London independent sector. In other words, although those providing care for children who are in poor health or with disabilities have not been included in the figures, staff that might care for children needing social care support as a result of a parent or carer facing death and dying have been included. Table four summarises the head count across South East London of those working within local authority employment within the Group B and Group C staff clusters.

Table 4: Headcount for social care staff employed by local authorities in SE London, September 2007

Head count: staff working with children only (who might readily be classified as Group C staff)	
Team leaders / managers, senior social workers, social workers and assistants, and care managers	**1,315**
Family centre, day nursery, play group workers	**60**
Head count: staff working with adults only	
team leaders / managers and senior social workers	**215**
care managers, social workers and assistant social workers	**640**
community workers and support workers	**140**
Occupational Therapists (OT) and OT Assistants	**105**
Domiciliary care organisers and trainee organisers	**75**
home helps / care staff and wardens	**375**
residential care staff	**285**
day care staff	**310**
Head count: staff working with adults and or children	
drivers, attendants / escorts	**425**
Other	
Undefined staff group	**205**

It is important to note that, a small indefinable number of the social workers listed as employed within these figures will work within Specialist Palliative Care and will therefore also be listed in that workforce data.

Recommendation:

19. **These figures give an indication of the number of Local Authority employed staff in South East London who would require either Group B or Group C minimum levels of training. It is likely that the majority of this workforce**

would correspond to the Group C staff clusters. However, this can only be determined at an organisational level and, in line with the information in figure seven, relevant minimal levels of training regarding end of life care should be incorporated into the Knowledge and Skills frameworks for individual posts and access by the worker to relevant courses enabled.

3.2.7.2 In October 2005 Skills for Care launched the National Minimum Data Set for social care (NMDS-SC). This is a data set that has enabled a coherent approach to information collection which has relevance to employers and the ability to provide an up-to-date picture of the social care sector. In appendix 7, recent independent sector workforce numbers for the six boroughs in South East London can be found. Though Skills for Care were unable to provide an indication of the response rate from organisations in South East London for NMDS-SC, they have stated that there is only an overall 70% national return rate of data from relevant organisations. Despite this, the data for South East London can be taken as a good indication of these workforce numbers for the sector. Table five provides a summary of this data relating to a head count of the Independent sector social care staff.

Table 5: SE London Independent sector social care staff head count; including permanent, temporary staff & vacancies, April 2009

	Private sector	Voluntary or third sector	Other
Care Home with Nursing	2,867	815	0
Care Home without Nursing	1.899	2,521	20
Other adult residential	76	189	0
Adult Day Care	27	92	156
Domiciliary Care	3,304	1,482	81
Other Adult Domiciliary Care	0	0	0
Adult Community Care	18	581	0
Other Service Types	27	18	0
SECTOR TOTALS	**8,218**	**5,698**	**257**
TOTAL= 14,173 staff			

Based within South East London are two hospices for palliative care adult patients, whilst there are an additional two such hospices based in surrounding sectors but providing a service to the population within South East London. In relation to the data in table five above, it is important to note that, for the former two hospices which function as voluntary sector organisations, Skills for Care have stated that their staff numbers are not incorporated into this data.

Recommendation:

20. **These figures give an indication of the number of social care staff employed in the independent sector in South East London who would require either Group B or Group C minimum levels of training. It is likely that the majority of this workforce would correspond to the Group C staff clusters. However, this can only be determined at an organisational, local authority or Primary Care Trust level and, in line with the information in figure seven, relevant minimal levels of training regarding end of life care should be incorporated**

into the Knowledge and Skills frameworks for individual posts and access for the worker to relevant courses enabled.

3.2.8 Although the national *End of Life Care Strategy* highlights that support staff can also frequently be exposed to work that involves meeting people with life-limiting illnesses, existing NHS and social care workforce data analysis activity does not generally identify the numbers of staff acting in such roles as caterers, porters, mortuary staff, housekeepers, drivers, grounds men, administrators, and fundraising staff, etc.

The national *End of Life Care Strategy* does not specifically identify where this group of staff fit into the framework illustrated in figure seven. Support staff clearly need access to some level of education about death and dying as many are likely to have contact with end of life care patients and some will deal with them frequently. However, this staff group represents a diverse range of workers and it is difficult to make broad statements about all their educational needs. Equally, it is important to determine what range of educational resources they would require to fully meet their needs in relation to the particular contact that they can have with end of life care patients and their families / friends.

Recommendations:

21. Employers of and individuals in these roles will need to consider which end of life care competencies relate to the individual post holder and determine educational needs accordingly.

22. Palliative and end of life care education providers should consider developing their education programmes to include the needs of support workers that come into contact with end of life care patients.

3.2.9 In relation to social care, there are many relatives, friends and volunteers caring for people alongside the paid workforce. Although the scope of this strategy is intended to be for the health and social care paid work force only, it is recognised that informal carers (generally family members, friends and neighbours of the patient) contribute significant levels of care giving and are vital in the provision of end of life care; particularly in the community setting. These informal caregivers will have particular educational needs of their own and, for relatives and friends, these

needs will be complicated by the emotional overlay of the experience of caring for their loved one.

As part of the government's ten year Carers Strategy: '*Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own'* (DoH, 2008), the Department of Health has invested £22 million within England to cover the costs of the establishment of information services via a help line and a training programme for carers. '*Caring with Confidence'*, the initiative aimed at improving support for carers aged 18 and over in England, is free and includes in its aims the development of expert carers via opportunities for them to attend local group sessions, complete self-study workbooks, by accessing online sessions or through a combination of all three.

More information can be found at: http://www.caringwithconfidence.net

Although this is clearly a useful resource, those who are informally caring for end of life care patients may have particular educational needs. In response to this need, Omega (as described in section 1.1.6) is aiming to facilitate the delivery of *Caring with Confidence* programmes for such informal carers. To achieve this, they are currently developing relationships with key stakeholders across the United Kingdom via contact with local Gold Standards Framework Facilitators in primary care.

Recommendations:

23. **The education needs of and training resources for informal carers in end of life care should be considered in a separate piece of work; in close consultation with existing relevant User Partnership Groups within South East London and with links to the work of Omega / Caring with Confidence.**

24. **As recommended in the national End of Life Care Strategy, Primary Care Trusts should develop local strategies for promoting public awareness with regard to issues around death, dying and end of life care.**

Although this will not address their educational needs during the caring phase of an end of life experience, it will possibly contribute in a small way to preparing members of the public as potential future end of life care informal caregivers, promoting some level of acceptance of death and dying as part of life and living.

3.3 The South East London Workforce - A training needs assessment

3.3.1 Phase I of the South East London Marie Curie Delivering Choice (MCDC) programme included eliciting the views of staff from all three staff groups (A, B, and C) as to where the gaps are in education and training in end of life care (see appendix eight for complete findings). Whilst the method employed by the MCDC project team to do this was not a comprehensive and systematic education and training needs assessment, it was of a whole systems nature; thus providing a valuable perspective from all the different angles, spanning health and social care, service users, and those involved at a management as well as those working in front line services. In addition, service redesign methods for the programme generally, using the patient pathway to identify barriers to care, also served to help identify the education and training needs of staff involved at each stage of the pathway. Both these methods were actioned through a variety of approaches, including interviews, focus groups, and anonymous questionnaires.

Despite low response rates to questionnaires (e.g. 13% of Lambeth GPs and 41 district nurses from across the entire sector), the general themes are in keeping with the national picture, essentially that many staff at all levels have received little or no training or Continuous Professional Development in end of life care.

3.3.2 This scoping exercise revealed the following ***general themes*** relating to the needs of staff for end of life care knowledge and skills:

1. The need to know how to recognise that the patient is entering the end of life phase:
    a. The need to be able to communicate the news sensitively and effectively
    b. How to deploy the Gold Standards Framework (GSF)

2. The need to recognise that the patient is now actively dying (diagnosing dying):
    a. The need to be trained in the use of the Liverpool Care Pathway (LCP) across all settings

3. The need to understand the relevance and applicability of palliative and end of life care skills to patients with non-cancer:
    a. Those with long term conditions

b. Those with conditions such as renal failure, motor neurone disease, multiple sclerosis, Parkinson's disease etc.

4. The need for palliative care training and support to front line generalist staff across all settings

5. The need to understand collaborative working between generalist and specialist palliative care services

6. The need to know how and when to have a discussion with a patient about their needs and preferences for their end of life care, and how to record it (e.g. Advance Care Planning; Preferred Priorities for Care)

7. The need for staff to be released for education and training in end of life care as a priority

8. The need to understand how funding mechanisms work to enable patients to be transferred to / remain in their place of choice (e.g. NHS continuing care funding).

3.3.3 **Additional themes** from questionnaire surveys

General practitioners (n=106) and District nurses (n=41) expressed similar education and training needs: in addition to the needs described in section 3.3.2 above they identified the need for training to be available in symptom management, medicines management, syringe driver initiation and management, cultural, social and spiritual care, working with families in distress, and Advance Decisions to Refuse Treatment (ADRT).

Care home managers (n=31) also raised similar issues for their staff but in addition wanted; amongst other things, to ensure that their staff knew how to implement and explain the GSF, and how to approach relatives of patients when an ADRT was to be implemented.

3.3.4 In summary, this scoping exercise provides a useful overview of the expressed education and training needs of a cross section of practitioners working across South East London. They are in keeping with the findings from the National Audit Office *Report on End of Life Care* (2008).

Recommendations:

25. Commissioners and providers of education and training should agree to the design and delivery of multiprofessional, multi-agency training programmes based not only on the national competencies and end of life care pathway, but with particular consideration of the findings of this scoping exercise

26. Organisations that employ and / or commission the end of life care workforce should ensure that training needs assessments are performed on a regular basis to inform the commissioning of programmes of education. This may form an annual review of end of life care training needs identified within staff appraisal systems.

3.4 Palliative and End of Life Care Education and Training provision

3.4.1 Introduction: Preferred education delivery and methods of learning

The South East London workforce numbers presented in the previous sections (3.2.4 to 3.2.8) support the observation within the national *End of Life Care Strategy* that the health and social care workforce is very large. Ensuring that all staff receive appropriate education and training in end of life care is therefore a challenge for both education commissioners and providers, with finite resources.

3.4.1.1 New opportunities provided by e-learning for Health for increased access to end of life care education (as described earlier in section 1.1.4) will offer some solution, and will allow education of the workforce without huge additional financial investment. Indeed the NHS national learning strategy; *Working Together—Learning Together: A Framework for Lifelong Learning in the NHS (DoH, 2001)* identified e-learning as a central strategic delivery mechanism and most United Kingdom universities are investing in e-learning for all their student categories, including health.

However, the use of e-learning often raises issues and concerns. Certainly research suggests that e-learning is more effective in combination (or blending) with traditional classroom based learning and that the level of personal support required in e-learning, e.g. through e-tutors, has been frequently underestimated (Childs et al, 2005). On a more positive note, the literature review by Childs et al (2005) of research exploring the effectiveness of e-learning in healthcare also

revealed that the majority of managers / trainers considered e-learning to be effective. Learners who were questioned also thought that e-learning was effective and improved education and training. Nevertheless, the managers and trainers added provisos that effectiveness is dependent on the way it is implemented and the attitude and skills of the learner.

3.4.1.1.1 To provide quality end of life care and establish meaningful and supportive relationships with patients and their families, healthcare providers themselves must be comfortable with death and dying (Kane, Hellsten, & Coldsmith, 2004). It is suggested that care workers exposed to dying patients, but lacking education in how to care for the dying, can develop death anxiety and negative attitudes toward care of the dying and eventual withdrawal from this care. In addition, health care professionals can struggle with inherent negative personal issues concerning death and dying and therefore be uncomfortable providing care at the end of life. For example, some studies highlight that reluctance to talk about death comes from health professionals, not patients or their relatives (Steinhauser et al, 2001; Rabow et al, 2003).

This clearly demonstrates that education is vital for the delivery of good end of life care, but also illustrates how such education can not only be the supply of appropriate knowledge but must also involve changing the attitudes, beliefs and behaviours of care workers with regard to death, dying and end of life care. Although there might be some scope for e-learning to include material that aims to change attitudes, beliefs and behaviours, it is unlikely to be able to provide the full range of required learning methods for those of the workforce who need to be able to explore difficult or painful experiences, thoughts, and feelings related to death, dying and end of life care. Therefore face-to-face educational methods cannot be excluded from any attempts to provide end of life care training to the health and social care workforce.

3.4.1.1.2 Transformative learning methods can allow educators to create an atmosphere in which learners are encouraged to evaluate their beliefs and views by using self-reflection. Change occurs as learners incorporate their new learning into their belief system and transform or reject their old beliefs. Palliative care provides an excellent example of a topic that lends itself readily to transformative learning theory (Mallory, 2003; Brendel, 2005). This might include role play, group process, and patient interaction.

3.4.1.1.3 Clearly the provision of good education and training in palliative and end of life care will need to involve blended learning through a mixture of:

- e-learning opportunities, particularly to support pre-course preparatory learning
- face to face education delivery using didactic learning methods for instilling evidence-based knowledge regarding factual palliative care information, for example the use of drugs in the control of symptoms
- face to face transformative learning methods for changing attitudes and behaviours about end of life care, and so improving the quality of patient-centred care

Recommendations:

27. Health and social care service managers in South East London should enable relevant members of their workforce to access learning opportunities via the Department of Health's e-learning for End of Life Care project but should also ensure they access other classroom based education in end of life care. Group A and Group B staff in particular should have access to end of life care education that includes transformative learning methods.

28. Providers of end of life care education in South East London should ensure that their courses include both didactic and transformative learning methods.

29. Education commissioners in South East London should ensure that end of life care courses for at least staff Groups A and B include transformative learning methods.

30. Given the prevalence of end of life patient contact within the health and social care workforce and the importance of education in the provision of high quality end of life care, it is strongly recommended that:

- **For all staff employed by caring organisations there should be a mandatory session on end of life care during employment induction**
- **Groups A and B staff groups have access to and complete mandatory training in end of life care relevant to their role and**

exposure to this work. For some Group A staff this is already established through requirements for academic qualifications in palliative care when following particular career pathways

- **For Groups A and B staff members, and as recommended within the national End of Life Care Strategy (see figure seven), this training should cover as a minimum the following subjects**: **communication skills, assessment and care planning, advance care planning, and symptom management as they relate to end of life care**
- **Group C staff members should at least have access to induction programmes that include training regarding the principles of end of life care**

Although it is recognised that, in health and social care, there are already a significant number of topics required for coverage in mandatory training and induction programmes, the information provided in this strategy demonstrates the importance of inclusion of end of life care training in compulsory training programmes. The introduction of mandatory 'safeguarding' training to all relevant clinical health and social care staff regarding the Provision for the Protection of Vulnerable Adults scheme from 2004 to 2007 onwards illustrates how it is possible to achieve this coverage in training successfully and in a relatively short time.

To deal with the issue of the large workforce to train, some basic education in palliative and end of life care could be delivered via cascade training.

Recommendation:

31. Education commissioners and providers should consider options for the creation of 'train the trainer' programmes to provide delivery of basic palliative and end of life care education through cascade principles of training.

3.4.1.1.4 The structures for supervision, development and training of front line staff should be subject to explicit structures of governance. Since Specialist Palliative Care providers have and will continue to develop a wealth of expertise within end of life care, staff who have significant or sole responsibility for end of life care as part of their job description must therefore have the necessary support from these specialists to provide safe and high quality care**.**

Recommendation:

32. For staff who have significant or sole responsibility for end of life care as part of their role, provision of adequate training, development and mentorship for them by appropriate specialist practitioners should form an explicit part of the professional accountability of these posts as part of their job description and contract.

3.4.1.2.1 Practice education is the term used to describe the part of a professional educational programme in which students gain 'hands-on' experience of working with patients under the supervision of a qualified practitioner. Although practice education is a compulsory element of many undergraduate courses for health and social care practitioners, it is not in common use within other courses, particularly for non-accredited education and training programmes.

However, research evidence suggests that practice education allows students to practise problem-solving skills, to observe and question the application of practice, and to 'gain insight into the reality of work and the pressures of the work environment' (Alsop and Ryan, 1996). In addition, it has been found that there are opportunities provided by practice education for students to develop 'attitudes and interpersonal skills essential for professional practice' including:

- A sensitivity to, and an understanding of, the needs of individuals
- The ability to relate and communicate in a professional manner
- The ability to suspend personal judgements and values
- Providing care which empowers patients to make informed decisions

Such learning methods would therefore clearly be valuable in palliative and end of life care education for the changing of attitudes and behaviours relating to death, dying and end of life care; as identified in section 3.4.1.1.1.

Example of good practice:

St Christopher's Hospice End of Life Care Programme for non-specialist nurses

St Christopher's Hospice, Sydenham, was approached by the Director of Nursing from a local acute trust hospital medical division to provide training in 'End of Life Care' to Ward Managers and Matrons. Funding and time had been ring fenced by the organisation to free each manager for one week in small groups of three or four over a period of four weeks in April 2008. The challenge for St Christopher's Hospice was to design a programme which would be able to effectively empower participants to return to practice equipped to make a sustainable difference to patient and carer experience in end of life.

Proposed learning outcomes were formulated and further developed into a range of competencies based on the Knowledge and Skills Framework (KSF). These were designed to assist the Ward Managers to evaluate their own competence and the competence of their workforce.

Led by the hospices' Advancing Practice Team (APT) facilitator, the week's programme offered a range of learning activities; via two practice based (participating and observing) days and three theoretical (listening and debating) days.
For the practice based days each participant was allocated to a specific ward within the hospice, where their clinical experience was supervised by hospice ward managers and participants were allocated to work with competent Staff Nurse mentors.
Specific time was allocated at the end of the week's programme for the participants to discuss service delivery and development of their workforce and to formulate an Action Plan for change, for self, team and the organisation.

Once all ward managers and matrons had completed the programme, they met as a whole group with the St Christopher's APT facilitator to receive overall feedback and were encouraged to present their collective 'Action Plan' to their acute trust senior managers for approval and support.

To sustain and implement the benefits of the programme, the APT facilitator continued to provide support by facilitating monthly Action Learning sessions for the whole participant group for a six month period following the completion of the programme.

Evaluation of individual participant satisfaction with this programme was extremely positive.
The Kings Fund are currently funding a formal evaluation of the programme as it is rolled out to two community teams and a team of deputy ward managers from another local acute hospital.

With thanks to Liz Bryan, Lecturer/Practitioner, St Christopher's Hospice/ King's College London

Recommendation:

33. Providers of end of life care education, health and social care service managers, and education commissioners should work together to develop programmes that include practice education. Such opportunities should in particular be made available for Group B categories of staff.

3.4.1.3.1 The specialist palliative care and generalist health and social care workforce contains practitioners of diverse disciplines playing fundamental but differing roles in the assessment of and care provision to end of life care patients. Working in teams has been an integral part of the philosophy of specialist palliative care since its early beginnings, enshrined in its standards and embedded in its practice. More

broadly in health and social care, interdisciplinary team working has become the preferred model of practice promoted by policy makers, professional bodies and organisational management. The promotion of interdisciplinary working is based on the assumption that when professionals pool their expertise, the work will be done more efficiently and effectively, and that patients will receive better care.

3.4.1.3.2 For a team to function effectively, the members must have a common purpose, an understanding of each other's role and ability to pool resources. It has been argued that such multiprofessional understanding is best achieved through interdisciplinary education (Carpenter 1995; Carpenter and Hewstone 1996). Research into shared learning (O'Neill, Wyness *et al* 2000) has revealed that interdisciplinary education promotes a greater understanding of other professions' roles and skills, begins to develop skills in interdisciplinary teamwork, and strengthens individual student's own professional identities. In addition, students can gain knowledge and skills in relation to complex illnesses and situations that require intervention from a range of professionals. Barr (2000) identifies that the inclusion of an interdisciplinary learning dimension in education programmes is only possible *'where learning applies to practice, teachers are seized with its importance, funding bodies are willing to make additional investment and competing objectives can be reconciled*'.

Recommendations:

34. Providers of end of life care education should ensure that their education programmes include opportunities for interdisciplinary learning and that these courses include opportunities for team based clinical case analysis and learning.

35. Health and Social care service managers should encourage relevant members of their workforce to attend courses that have an interdisciplinary approach. This may involve allowing the release of complete teams from clinical work to attend such training.

36. Education commissioners in South East London should ensure that palliative and end of life care courses include opportunities for interdisciplinary learning.

3.4.1.4.1 Libraries are established for the systematic collection, organization, preservation and dissemination of knowledge and information. As such they are an important

resource for learning. Across SE London there are a number of NHS libraries that act as a resource for access to literature relating to healthcare. These are listed in appendix nine and include the specialist palliative care library based at St Christopher's Hospice. All these libraries will hold varying amounts of material relating to end of life care. Some of these allow access to relevant staff working outside the NHS and it is recommended that individuals contact them to ascertain their membership regulations. In addition the resources available within these libraries can be searched via the following web-address:

www.selhl.nhs.uk/uhtbin/cgisirsi/OOf97p3vIf/BROMLEY/0/49

Equally the internet offers many opportunities for access to academic articles and literature. For example, the Oxford Handbook of Palliative Care is available as an e-book and, in relation to professional journals, both Palliative Medicine and the International Journal of Palliative Nursing are available in full text to within the last few issues.

3.4.2 Mapping and analysis of current palliative and end of life courses for South East London

3.4.2.1 In early 2008, the South East London Palliative and End of Life Care Education and Training working group developed and circulated a template for a mapping exercise. The aim of this was to reveal the extent and profile of palliative and end of life care education and training courses delivered between January and December 2007. Once returned, information was gathered and analysed.
In order to ensure as complete a picture as possible, this exercise was repeated a year later and covered course provision during 2008.

3.4.2.2 The mapping template was sent to all hospices and Specialist Palliative Care Teams serving South East London, all six Primary Care Trusts, the London Ambulance Service, national charitable organisations who deliver palliative and end of life care training, mental health care trusts in South East London, and the Lambeth, Southwark and Lewisham Care Homes Support Team.

The template was also sent to the Higher Education Institutes and larger Further Education Colleges in South East London. These included Bromley College, London Southbank University, Greenwich University and King's College London. Since there is agreement between these colleges that King's College London leads

on the local delivery of accredited post-registration palliative care courses, this is the only college that features in the findings that are presented below. With regard to undergraduate nurse training, both King's College London and Greenwich University have confirmed that, in light of the publication of the national *End of Life Care Strategy*, they have reviewed and revised their courses to reflect the recommendations within that document.

3.4.2.3 The response rate to the request for information was good and completed mapping templates with information regarding both 2007 and 2008 courses were received from the following organisations and teams:

- St Christopher's Hospice
- Greenwich and Bexley Cottage Hospice
- EllenorLions Hospice
- Harris Hospiscare; now Harris Hospiscare with St Christopher's
- Queen Mary's Sidcup, Hospital Specialist Palliative Care Team
- University Hospital Lewisham, Hospital and Community Specialist Palliative Care Team
- King's College Hospital, Hospital Specialist Palliative Care Team
- Guy's and St Thomas' Hospitals, Hospital and Community Specialist Palliative Care Team
- Queen Elizabeth Hospital, Hospital Specialist Palliative Care Team
- Lambeth, Southwark and Lewisham Care Homes Support Team
- King's College London- Department of Palliative Care Policy and Rehabilitation
- King's College London- Florence Nightingale School of Nursing
- Marie-Curie Cancer Care
- Help the Hospices

For other organisations that were asked to provide information:

- The Modernisation Initiative End of Life Care Programme provided details of a small number of courses provided internally by the South London and Maudsley NHS Foundation Trust, with one of these being in conjunction with St Christopher's Hospice
- The London Ambulance Service acknowledged the request for information, but currently has no internal provision and is attempting to

develop an end of life care education programme for their staff, probably via e-learning packages

- Primary Care Trusts deliver no end of life care training themselves though a number of them have commissioned courses from their local hospice for their own staff and / or for social care staff
- The Hospital Specialist Palliative Care Team at the Princess Royal University Hospital provided a completed a template for the initial mapping of 2007 courses only
- No responses were received from Trinity Hospice

3.4.2.4 The mapping template enabled the disclosure of the following information relating to palliative and end of life care courses delivered in 2007 and 2008:

- Title of courses and course outline
- For each education and training course:
  - Which professional groups the course is aimed at
  - The geographical and / or organisational catchment area for potential students
  - Which professionals deliver the course
  - Whether the course is validated
  - The length of the course
  - Number of places available
  - Frequency of delivery
  - Cost per student or course
- Issues and obstacles to education provision

3.4.2.5 A summary of mapped palliative and end of life courses and their profiles can be found in appendix ten[3]. Information about courses is grouped and organised in relation to the end of life care pathway presented earlier in figure two. Details of

[3] Some information about courses run by Help the Hospices is included in these findings, though a full list of 2007-8 courses was not available at the time of the mapping exercise. There is also available a Certificate in Palliative Care at NVQ Level 3. As this is provided by an indeterminate number of independent training and consultancy businesses as well adult education colleges, details of this is not included in the mapping but should be acknowledged.

training in end of life care for medical students at King's College London are given separately in appendix eleven.

NB. General training and education programmes (e.g. mandatory training, leadership and management skills, study and teaching skills, etc) are not included since they are not directly relevant to this strategy. Equally paediatric palliative care courses, although in existence, are excluded as this is an education strategy relating to the care of adults.

3.4.2.6 A number of organisations responded to the request for information about courses they were planning or had planned for 2009, as listed in appendix twelve. Comparison with information provided for 2007 and 2008 demonstrates that education providers are generally actively adjusting their courses on an annual basis.

One of the limitations of this mapping is that providers were not asked to indicate the rationale for adjustments in course programmes and whether this decision-making was based on revealed training needs of staff or on the education providers anticipating what the needs of the workforce might be. However, since some respondents voluntarily indicated that some of the courses delivered for individual professional groups *are* commissioned from them by Primary Care Trusts, it is assumed that these courses *will* have been commissioned because of an identified need for the development of skills and knowledge for particular staff groups. As illustrated in section 3.3.4, the delivery of courses that are responsive to workforce training needs analysis is vital. Recommendations made in this previous section are relevant to this issue.

3.4.2.7 Of those organisations and teams who supplied information regarding obstacles to the delivery of end of life care education and training, the issues revealed included:

- **Funding**
  - Uncertainty of spending on / funding training and development (2 hospices)
  - Uncertainty of ongoing funding for care homes courses (1 hospice)
  - Recent decrease in investment in nurses / staff training by acute trusts and Primary Care Trusts (1 hospice- 2007 comment)

- **Staff resources**
  - Lack of protected time for Specialist Palliative Care (SPC) Team members to organise education provision
    (3x acute trust SPC teams)
  - Understaffing of Specialist Palliative Care Team, hindering provision of education (2 acute trust SPC Teams, 1x hospice)
  - Lack of administrative support
    (3 acute trust SPC Teams + 1 hospice)
  - Low attendance by District Nurses due to high community workload (1 hospice)
  - Care home attendance only high when education free (1 hospice)
  - Poor attendance by ward staff- *NB Possible reason not given*
    (4 acute trust SPC Teams)

- **Attitudes to training need**
  - "Low uptake of places; some training needs are not always given the priority they deserve by the care homes"

- **Inter-organisational working**
  - "As a stand alone provider, we have to work hard at developing partnerships with universities, some of which have little experience of the charity sector" (1x hospice)

In relation to most of these issues, they are likely to be resolved through implementation of the recommendations made elsewhere within this education strategy.

With regard to the funding issues raised, although this mapping omitted to request information regarding the source of funding for the delivery of courses, intelligence outside of this exercise confirms that opportunities for meeting the costs for delivery of end of life care training are variable between education providers. As will be seen later in part 4, *Current Arrangements for Education Commissioning and Funding*, academic courses have a relatively clear funding stream. However, voluntary sector hospices, for example, frequently rely on funding for their courses from a variety of sources, some of which are unpredictable and unreliable, including charitable monies, medical deanery, educational contracts, and via

commissioning from provider organisations. As shall be recommended in part 4, these organisations also need to be included in established and future South East London education commissioning plans to ensure a stable income for the delivery of courses.

Recommendation:

37. **In relation to the issue of poor course attendance due to the cost of courses and given the importance of raising standards in the quality of end of life care, commissioning plans should enable health and social care workers to receive core end of life care education and training without having to self-fund.**

The mapping reveals that specialist palliative care professionals deliver a large proportion of end of life care education and are therefore an essential resource due to their expertise. It is therefore vital that their release from practice is facilitated so that they can teach on both non-accredited and accredited courses. Barriers to this can be a resource issue- due to their clinical default, a financial issue- with a need for backfill payments to cover their clinical absence, and an attitudinal issue- as their clinical work can sometimes take priority.

Recommendations:

38. **When negotiating the commissioning of palliative and end of life care education programmes, commissioners and education providers should include the cost of backfill for clinicians acting as educators.**

39. **Specialist Palliative Care professionals should acknowledge their expertise and importance in the delivery of palliative and end of life care education to the generalist workforce, ensuring that this role is prioritised in their work planning.**

3.4.2.8 Mapping reveals that, for 2007-8, there was delivery of a significant number of education and training opportunities, with a total of at least **164** available to staff in South East London, ranging from short sessions within inductions to fully accredited academic modules and courses. However, these were not coordinated across the sector.

3.4.2.9 Of education and training opportunities revealed through mapping, **21** were described as accredited[4] courses and table six illustrates the range of accrediting bodies and the number of courses these organisations are linked with.

Table 6: Numbers of accredited end of life care courses in SE London, 2007-8

Accrediting body	Number
Connected	3
King's College London	10
Middlesex University	2
Open University	1
University of Kent	1
Bromley College	1
National Gold Standard Framework Team	1
Accredited through Continuous Professional Development (CPD) approval	2

In addition, **4** hospital based specialist palliative care teams and **4** voluntary sector hospices provide the opportunity for learning through clinical placements or visits, demonstrating that practice learning is available within the sector.

3.4.3.0 Both the national *End of Life Care Strategy* and this education and training strategy recommend that course programmes and course curricula should be based on the end of life care pathway as illustrated earlier in figure two. The information about courses in appendix ten is therefore grouped and organised in relation to this pathway in order to establish if course provision during 2007-8 was congruent with all its component parts. Table seven suggests that such education and training opportunities already exist in line with the end of life care pathway. That said future planning of the delivery of education and training will require considerable coordination to ensure equitable access across the whole sector and sufficient coverage of all topics relating to the care pathway.

Since organisations were not asked to provide details of course curricula or learning outcomes for courses it is not possible to determine if the courses delivered in 2007-8 were competency-based. In addition, due to insufficient data from the mapping in relation to the numbers of places available on end of life care courses, it is not possible to judge whether sufficient places are available for the size of workforce across South East London, as identified in section 3.2.

[4] Accreditation refers to ratification by national bodies / initiatives or to academic / vocational accreditation from a university / college

Table 7: End of life care courses for SE London- 2007-8, subdividing according to end of life care pathway[5]

Component of the end of life care pathway	Topic	Number of courses delivered	Maximum number of staff available to over whole period	Comments
Discussions as the end of life approaches	Communication- advanced level	3	125	Mostly attended by nurses though is a multi-professional course
	Communication- basic & intermediate	9	203+ unspecified	
	Communication- breaking bad news	1	24	1 course for medical students
	Advance Care Planning	1	Unspecified	
Assessment, care planning and review	Palliative care needs- disease specific	5	60+ unspecified responses	Focus on Dementia during 2008
	Drugs & symptom control- general	6	68	Provision generally for multi-professionals
	Drugs & symptom control- symptom specific	9	158+ unspecified	Provided for a range of professional groups, some specifically targeted and some as multi-professional groups. Majority of these study sessions occur annually and are provided by both SPC teams and Hospital Trusts.
	Drugs & symptom control- syringe drivers	13	766+ unspecified	Good provision across SELCN for basic syringe driver training by SPC providers for nursing staff working in the community, the acute sector and care homes. Sessions generally provided free or at low cost.
	Emergencies in cancer palliative care	2	50	
	Palliative care Rehabilitation	2	12+ unspecified response	Multi-professional access
	Palliative Care wound care	2	Unspecified	Provided for nurses at an introductory and advanced level
	Nutrition	2	30+ unspecified	
	Prognostication	1	Unspecified	
	Non-medical prescribing in end of life care	1	Unspecified	
	DNAR training	1	40	

[5] Some education sessions, particularly amongst those provided by hospital based specialist palliative care teams were delivered within induction programmes

Component of the end of life care pathway	Topic	Number of courses	Maximum number of staff available to over whole period	Comments
Coordination of care	Models of care & developing care services	7	62+ unspecified responses	Sessions look at a range of services and national initiatives that are topical- e.g. GSF All provided by St Christopher's Hospice and predominantly targeted at specific groups of staff.
	Role of & referral processes to Specialist Palliative Care Teams	4	Unspecified	
Care in the last days of life	Care in last days of life (including use of LCP in majority of these courses)	16	400+ unspecified responses	Provision by a range of service providers within SELCN for a range of workers- from AHP, nursing and medical staff to HCAs in a variety of settings e.g. care homes and mental health for older adults.
Care after death	Loss, grief and bereavement	19	867++ unspecified responses	Variety of courses provided, from short sessions to post-graduate diploma. Majority of courses provided by St Christopher's Hospice. Some training sessions targeted for specific groups e.g. school staff, volunteers. Other sessions have open access for a range of staff to attend.
Overarching themes	Principles of Palliative & End of Life Care	36	1030+ unspecified responses	Good provision across the network by SPC services and Higher Education Institutions Many of these courses are not formally accredited Some courses are accessible to staff working within SELCN but are also promoted nationally Accessible to a range of heath care staff reflecting multi-professional working and including students, unqualified and qualified staff. Some courses/ study days have specifically targeted audience
	Spiritual & cultural care, including equality & diversity	3	20+ unspecified	
	Ethical issues	7	108+ unspecified responses	For all staff groups
	Psychological & social care	12	55+ unspecified	
	Evidence based care in Palliative Care Nursing	1	Unspecified	
	Changing attitudes to death & dying	1	Unspecified	

3.4.3 Other future and current opportunities for end of life care workforce development in South East London

3.4.3.1 From March 2009, King's health partners have been formally accredited as one of the United Kingdom's first Academic Health Science Centre - with the partners, King's College London, Guy's and St Thomas' NHS Foundation Trust, King's College Hospital, and the South London and Maudsley NHS Foundation Trust. It will be the challenge of this new body to make full use of its potential to revolutionise the way that health care is designed and delivered, both for the local population and beyond.

3.4.3.4 Within the South East London Marie Curie Delivering Choice Programme (MCDCP), and in conjunction with St Christopher's Hospice, a work stream has focused on the development of a proposal for the improvement of end of life care in care homes through the implementation of :

- Gold Standards Framework in Care Homes – ongoing for care homes (nursing) / new facilitation for care homes (without nursing)
- The adapted Liverpool Care Pathway for care homes
- A facilitative learning programme in palliative care: 'Foundations in Palliative Care for Care Homes' (Macmillan 2004)
- Work with specialist palliative care teams to involve them in supporting educational initiatives and role modelling

Success of this proposal and therefore the improvement of the skills and knowledge of care home staff depends on individual Primary Care Trusts extending funding for Care Home Facilitator posts within their localities beyond March 2010.

Recommendation:

40. Given the unfavourable findings relating to care home staff skills in end of life care provision as described in the National Audit Office (NAO) *Report on End of Life Care* (2008), Primary Care Trusts should support with funding these proposals set out by the MCDCP in conjunction with St Christopher's Hospice.

4. CURRENT ARRANGMENTS FOR EDUCATION COMMISSIONING & FUNDING

Exploring the issues and identifying opportunities for South East London

4.1 Nationally there is no one single process for the funding of the education and training of all health and social care professionals and care givers. It is indeed perhaps inevitable that this should be the case for a workforce that is employed by different types of organisations- statutory, private and voluntary, and who come from many different professional groupings, with some qualified and others not.

4.2 To attempt to clarify the current status for funding education and training for this workforce, sections 4.2.1 to 4.2.4 describe the main existing systems, in particular for members of the workforce who have access to pre- and post-registration training, as well as describing areas where these processes are likely to change.

4.2.1 For England, with respect to the education of **NHS-employed health care professionals**, both the Higher Education Funding Council for England (HEFCE) and Strategic Health Authorities such as NHS London (NHSL) are responsible for the distribution of public money for teaching and research to universities and colleges, as well as to education leads and commissioners within NHS trusts. For Strategic Health Authorities, funding is provided from the Department of Health (DH) as a Multi Professional Education and Training budget (MPET) comprising of Non-medical Education and Training (NMET), the Medical and Dental Education Levy (MADEL), and the Service Increment For Teaching (SIFT). For the HEFCE, funding is provided from the Government Department of Innovation, Universities and Skills and generally funds medical training. Figure nine illustrates the existing processes for devolving this funding across London and figure ten outlines the purpose of MPET funding. These illustrations are sourced from an NHS London report (2007) regarding the Development of an Education Commissioning System.

4.2.1.1 To add to the complexity of these funding flows, HEFCE also funds some non-medical health-related subjects such as dentistry, post-registration nursing, subjects allied to medicine, and pharmacy. In addition, they have supported the introduction of a large number of healthcare foundation degrees, creating employment pathways into the NHS, and modernising health education and training.

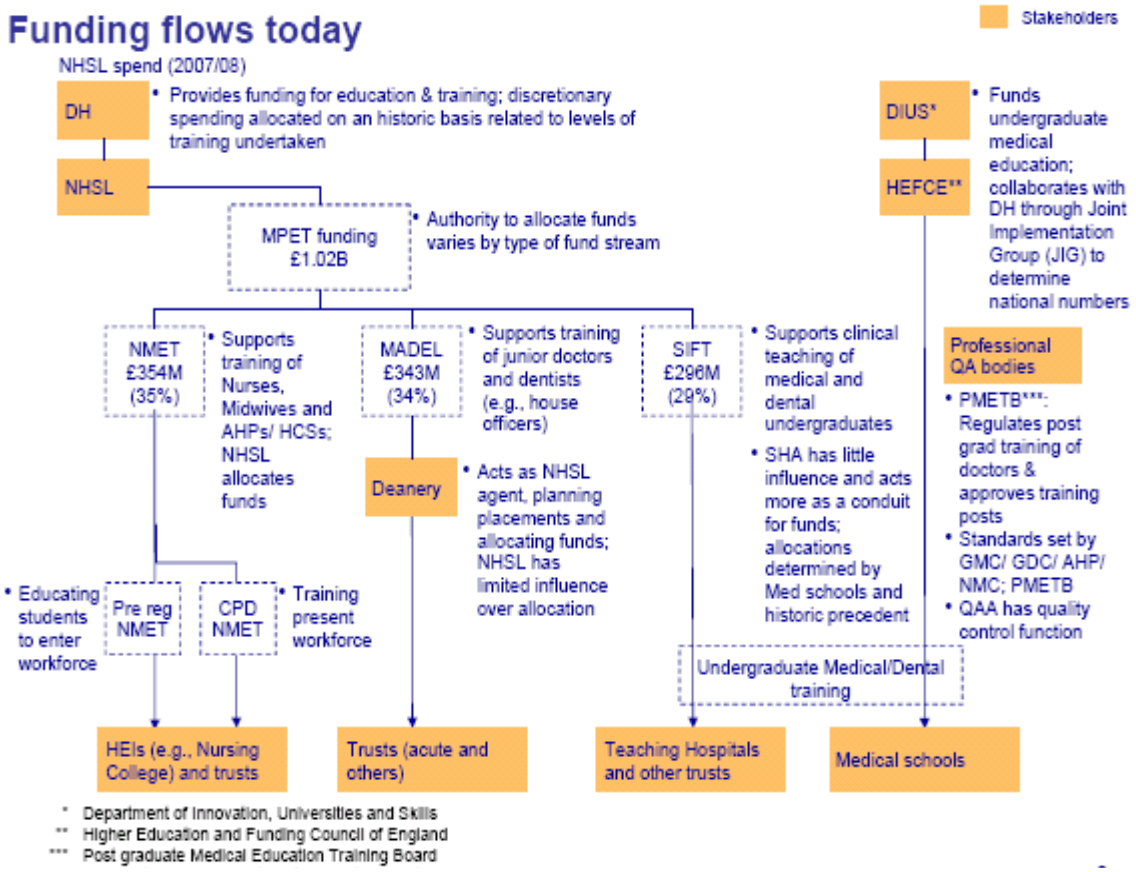


Figure 9: Funding flows for London prior to proposed SHA education commissioning reform

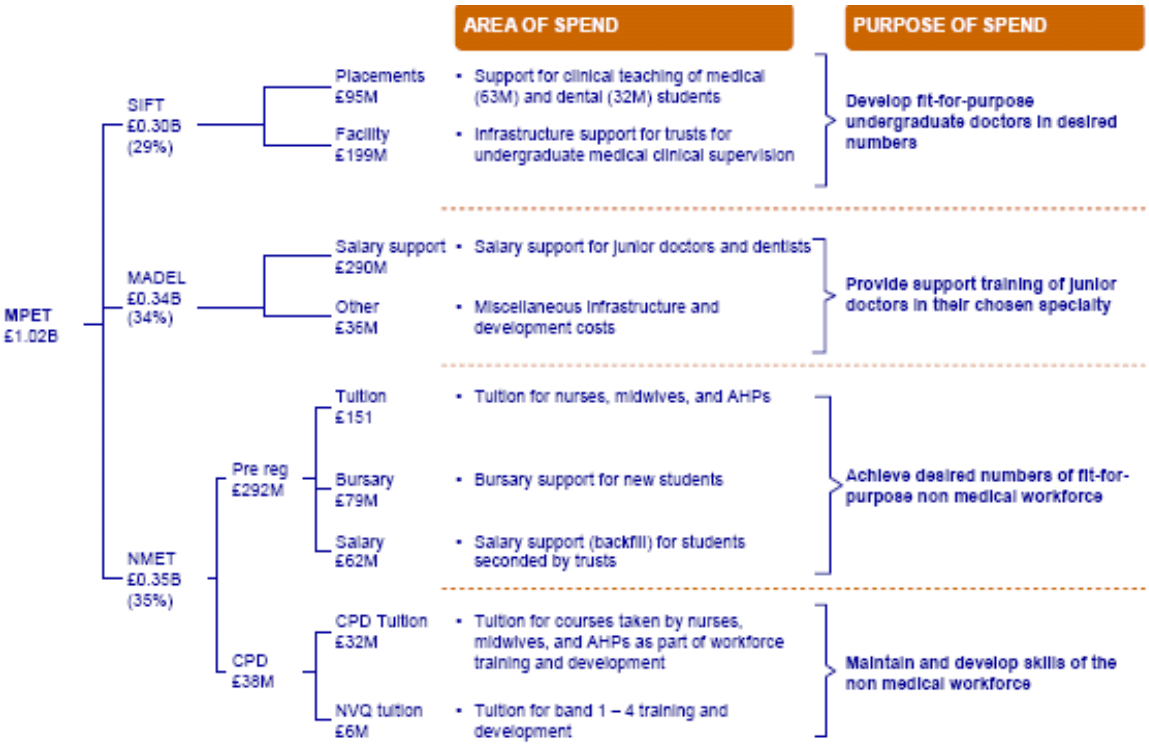


Figure 10: Purpose of MPET funding

4.2.1.2 As described earlier in section 2.2, NHS London, through its Workforce for London strategy, plans to reform its education commissioning system. In April 2008, its Education Commissioning team established a programme to undertake this work. Between April and December 2008, Phase I of the Education Commissioning Programme focused on improving non-medical education commissioning and achieved:

- Alignment of education commissioning intentions with workforce strategy commitments
- Introduction of a new contractual framework for pre-registration education
- Introduction of a new Quality Assurance System.

Before 2008, only 4% of the £1billion spent each year by NHS London on training and education was invested in Continuing Personal and Professional Development (CPPD) of the existing NHS workforce (McKinsey & Co, 2007). In recognition of the need to increase CPPD funds and in line with intentions described within the Workforce for London Strategy, Phase I has also included the development of a robust process for allocating additional CPPD funds which become available from time to time. In August 2008, NHS London invited bids for a total of £15million additional CPPD funding and received over 240 bids from over 60 NHS organisations across London. Of the bids received, 75% were successful. Bids covered a wide range of staff groups including health care assistants, allied health professionals, clinical leaders, and scientists working in the NHS. Although it is currently unclear how frequently the opportunity to bid for additional CPPD funding will occur, this is undoubtedly an important potential additional resource for the financing of end of life care education and training.

Recommendations:

41. Education leads, commissioners and providers should ensure that opportunities to submit bids for additional CPPD funding are undertaken to enable an increase in access of their staff and staff from related services to end of life care education and training.

42. Education providers should have available fully costed education programmes, so that incidental funding opportunities can be actioned promptly.

4.2.1.2.1 Phase II of the Education Commissioning Programme will include the development of an Education Commissioning Hub (ECH). It is proposed that this hub will take over from the current NHS London Education Commissioning Team and will manage the commissioning of relevant education across London. It will significantly expand NHS London's remit to cover more of the end-to-end commissioning process than undertaken currently. An options appraisal of possible organisational structures and functions for the ECH was out for consultation during summer 2009 and can be seen in figure eleven. The engagement process was conducted via focus groups, interviews and a survey and the consultation completed during July 2009. NHS London plan to maintain dialogue with stakeholders over subsequent months as plans are formalised and will present a final plan for the functions of the ECH in early autumn 2009.

In parallel with these developments, work has also been underway to streamline the current range of contractual agreements which govern education and training, replacing them with a single cohesive Learning and Development Agreement (LDA).

Figure 11: Four potential models for future functioning of education commissioning

Source: Development of the Education Commissioning Hub: Engagement Document June 2009

Option 1: SHA Model - NHS London manages entire education commissioning process

Features	SHA Model (SHA manages entire education commissioning process)
Functional Description	NHS London owns the decision-making and all other activities in the education commissioning process i.e. planning, contracting, provider management (including quality assurance) and market management for all streams of education An education commissioning team within the SHA has capacity and capability to provide transactional, expertise and relationship support to the decision-makers Elements of continuing professional and personal development will be planned at the Trust level but contracting and quality assurance can be moved to the pan-London, Sector or PCT level
Location and governance	The ECH is located within NHS London Education providers will liaise direct with NHS London National advisory bodies will liaise with NHS London where necessary

Option 2: ECH model - ECH manages and owns all aspects of the education commissioning process

Features	ECH model – ECH manages and owns all aspects of the EC process
Functional Description	ECH owns the entire education commissioning process (i.e. planning, contracting, provider management (including quality assurance) and market management for all education, except specified elements of continuous professional and personal development. ECH is a unit that is focused on education commissioning and has specialised teams providing transactional, expert and relationship support to the decision-makers through each stage of the education commissioning process Elements of continuous professional and personal Development will be planned at the Trust level but contracting, and quality assurance can be moved to the pan-London, Sector or PCT level
Location and governance	ECH is established as a body at arms length from NHS London (potentially within an existing organisation such as Commissioning Support for London) NHS London would be part of governance group of ECH and would have an overview of non-London-focused education commissioning decisions Education providers will liaise direct with the ECH National advisory bodies will liaise with the ECH where necessary

Option 3: Sector model - ECH supporting the education commissioning process but decisions taken by the 'Sector'

Features	Sector model – ECH supporting the education commissioning process but decisions taken by the 'Sector'
Functional Description	ECH provides transactional, expertise and relationship support through all stages of the education commissioning process planning, contracting, provider management (including quality assurance) and market management for all streams of education except specified elements of continuous professional and personal development Sectors, made up of groups of NHS organisations, own decision-making and are accountable for all education commissioning except specified elements continuous professional and personal development. They have sufficient expertise to make intelligent buying decisions Elements of continuous professional and personal development will be planned at the Trust level but contracting and quality assurance can be moved to the pan-London, Sector or PCT level
Location and governance	ECH is established as a body at arms length from NHS London (potentially within an existing organisation such as Commissioning Support for London) NHS London would be part of governance group of ECH and would have an overview of non-London-focused education commissioning decisions Education providers will liaise direct with the ECH National advisory bodies will liaise with the ECH where necessary

Option 4: Hybrid model - Education commissioning decisions split at pan-London and Sector level based on nature of education

Features	Hybrid Model – Education commissioning decisions split at pan-London and Sector level based on nature of education
Functional Description	ECH owns entire education commissioning process (i.e. planning, contracting, quality assurance, provider management and market and curricula development) for all education, except specified elements of continuing professional and personal development ECH is a unit that is focused on education commissioning and has specialised teams providing transactional, expert and relationship support to the decision-makers through each stage of the education commissioning process Sectors, made up of groups of NHS organisations, take commissioning decisions on investment in certain parts of the training portfolio. They have sufficient expertise to make intelligent buying decisions Elements of continuous professional and personal development will be planned at the Trust level but contracting, and quality assurance can be moved to the pan-London, Sector or PCT level
Location and governance	ECH is established as a body at arms length from NHS London (potentially within an existing organisation such as Commissioning Support for London) NHS London would be part of governance group of ECH and would have an overview of

Features	Hybrid Model – Education commissioning decisions split at pan-London and Sector level based on nature of education
	non-London-focused education commissioning decisions Education providers will liaise with the ECH directly National advisory bodies will liaise with the ECH where necessary

4.2.1.2.1.1 As can be seen within section 3.4.2, the majority of palliative and end of life care courses available in South East London during 2007-8 were delivered by education providers other than Higher Education Institutions, with over 60% of these courses being delivered by voluntary sector hospices. Although final decisions about the function of the ECH and about which body will be responsible for it are yet to be made, it *is* possible that it will procure on behalf of both locally devolved and pan-London education commissioning decisions. If this is the case, it will be important for relevant staff within the ECH to be able to engage during their commissioning cycles with the full range of organisations providing palliative and end of life care education and training, ensuring plurality of provision and value for money.

Recommendations (if options 1 or 2 adopted):

43. Education leads and commissioners within NHS organisations as well as education providers should ensure that the newly formed Education Commissioning Hub, if procuring palliative and end of life care education, engages with the full range of relevant education providers in South East London as indicated via the 2007-8 course mapping in section 3.4.2

44. If procuring palliative and end of life care education and training themselves, education leads and commissioners within NHS organisations should engage with the full range of relevant education providers in South East London as indicated via the 2007-8 course mapping in section 3.4.2

If decision-making is devolved to **sector level**, there will need to be a decision regarding which organisation(s) and / or group(s) would have this responsibility. For South East London, and in line with the pan-London NHS Strengthening Commissioning Initiative, there had been a proposal in February 2009 within *Strengthening Commissioning in SE London: Summary of Outline Business Case for the Sector Commissioning Vehicle* for the development of a number of clinical networks for the sector wide commissioning of related services and workforce for South East London. This had included an End of Life Care Clinical Network. The South East London Cancer Network, which is currently responsible for the South East London Palliative and End of Life Care Programme, during March 2009, provided the Joint Committee of Primary Care Trusts (JCPCT) for South East London and NHS London with proposed collaborative commissioning intentions

(CCIs) for this End of Life Care Clinical Network. These collaborative commissioning intentions mirrored similar CCIs for other sectors across London and included the recommendation that the South East London End of Life Care Clinical Network should handle sector wide commissioning of end of life care education and training. However, during summer 2009 and unlike some other sectors such as North East London where this approach is being progressed, the idea of sustaining such an end of life care clinical network was reversed and is therefore no longer available within South East London as an organisation to hold this responsibility.

The new structure for the commissioning of care provision in South East London is illustrated in figure twelve. As can be seen in this diagram, there are a number of organisations within the structure that function at full or partial sector wide level. These include the following that constitute a Sector Commissioning Vehicle:

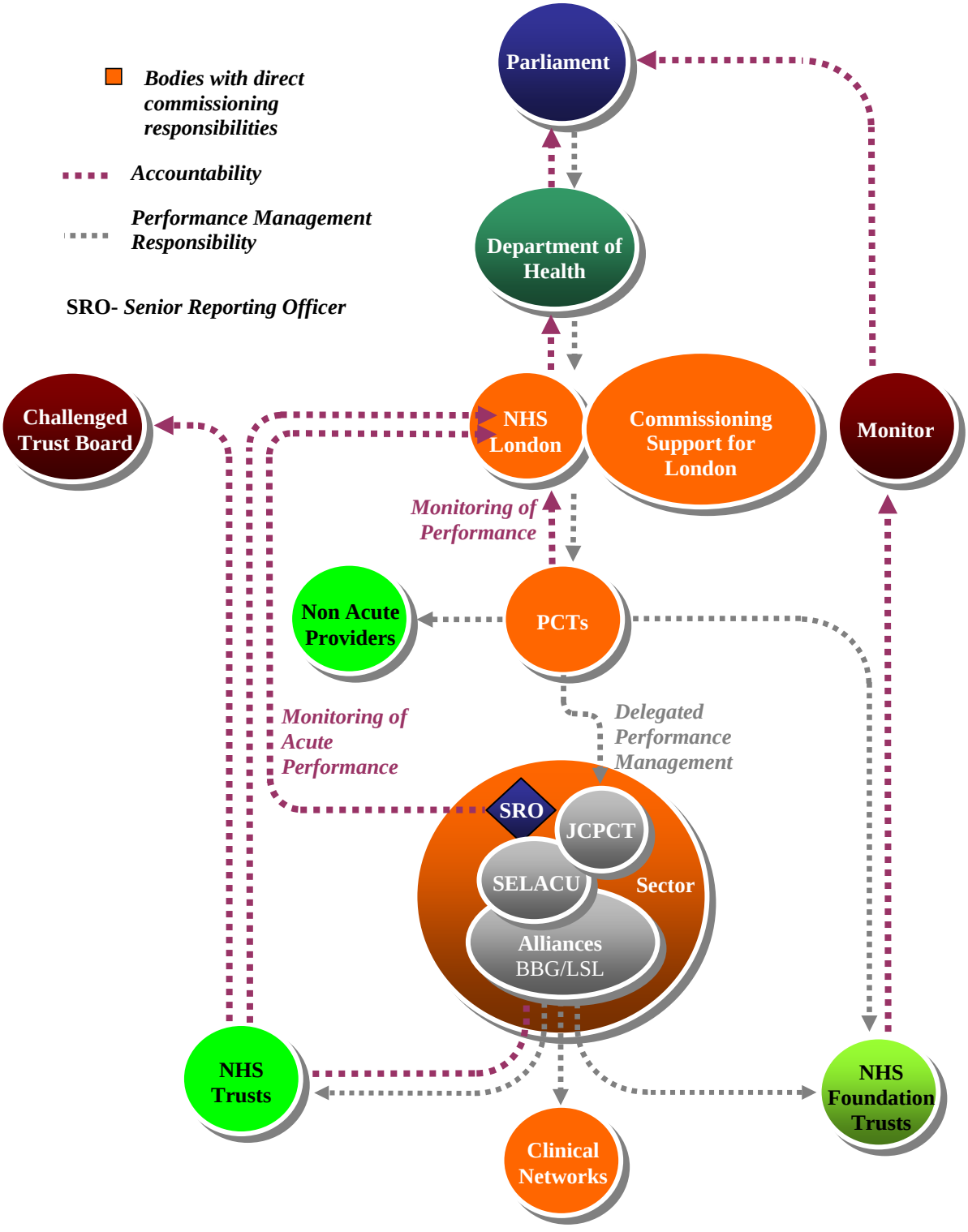
- the Joint Committee of Primary Care Trusts (JCPCT) will oversee activity of the sector commissioning vehicle

- the South East London Acute Commissioning Unit (SELACU), that will:
  - Commission for strategic change and improvement through Clinical Networks;
  - Lead performance management of acute services throughout South East London; and
  - Support PCTs in the attainment of World Class Commissioning

- Clinical networks, including for cancer, that will on behalf of SELACU focus on acute commissioning relating to their speciality

- the two Alliances, the Bexley, Bromley and Greenwich (BBG) Alliance and the Lambeth, Southwark and Lewisham (LSL) Alliance will focus on the commissioning of secondary acute services focused on a common set of providers, and similar population health needs

Figure 12: New framework for commissioning care in South East London, including sector performance reporting flows and links to pan-London & national organisations



The Clinical Networks are Cancer, Cardiac, Stroke, Complex Paediatrics, Adult Critical Care, High Risk Maternity and Neonatology, and Trauma

In developing the sector commissioning vehicle (SCV) for South East London there has been no suggestion that any of these bodies would become involved in the commissioning of education and training for the health care or indeed social care workforce. If a later decision was reached for the SCV to take on this responsibility, it would need advice for its decision making from experts in the provision of care and its related education. In the context of this education strategy, it would need help to understand palliative and end of life care and its related education and training provision.

Recommendations (if options 3 or 4 adopted)

45. Although the alliances or individual PCTs may play some part in decision making regarding the commissioning of palliative and end of life care education and training, it remains more logical to focus this work at sector level and this should be the approach.

46. If palliative and end of life care education and training commissioning for South East London became the responsibility of SELACU, a reference group made up of clinicians and educationalists would be required to inform their decision making. The existing South East London Palliative and End of Life Care Coordinating Group, which is managed currently by the South East London Cancer Network, could provide this expertise.

47. The maintenance of an End of Life Care Clinical Network for South East London is strongly recommended since, as well as other components of commissioning such as workforce development and service quality measurement, palliative and end of life care education and training commissioning would be best approached at a sector level.

4.2.1.3 The Department of Health's national End of Life Care Programme has been successful in ensuring that the Multi Professional Education and Training (MPET) levy for 2009/10 includes an indicative £12.8 million of funding relating to end of life education and training, and the accompanying Service Level Agreement requires Strategic Health Authorities to develop investment plans that include workers in all settings where people may die.

4.2.1.3.1 For NHS London, this funding will apparently be devolved in two stages to Primary Care Trusts; with a first sum during the 3rd Quarter of 2009 and then the second sum in 2010/11.

During September 2009, a letter was circulated to inform these organisations of their responsibility to use these monies for the education and training of both health AND social care staff in end of life care. As with other funding provided in parallel with the publication of the national End of Life Care Strategy, this allocation of monies for London will unfortunately not be ring fenced amongst other MPET monies for education and training. It has also not been clarified how much of the total MPET funds supplied are allocated for this purpose. However, allocation will be on a per capita basis and it can therefore be assumed that the total amount for 2009/10 and 2010/11 for South East London should be as follows[6]:

Lambeth	£92,767
Southwark	£78,808
Lewisham	£77,560
Greenwich	£67,839
Bexley	£51,396
Bromley	£74,573

Recommendations:

48. Primary Care Trusts in South East London should ensure that this funding is fully spent on optimising access for both health AND social care staff to palliative and end of life care education and training.

49. Social and health care provider organisations in both the statutory, voluntary and independent sectors should campaign for Primary Care Trusts to fully spend this funding on the provision of end of life care education and training for their staff.

4.2.1.3.2 In April 2008, Skills for Health published '*Staff Learning and Development Funding: Guidance for Employers'*. This guide details a range of ways of funding staff learning and development for healthcare employers and includes sources of information and services related to funding that could be useful for accessing end

[6] The calculation for these amounts employ the method used by Help the Hospices to estimate the main allocation of End of Life Care Strategy monies to Primary Care Trusts

of life care education and training. The document can be found at www.skillsforhealth.org.uk

4.2.2 For ***social workers***; since 2005-06, students on new social work degree courses have been required to join the Social Care Register prior to commencing their first placement. Practice learning funding for the degree is now linked to this student registration. In addition, the General Social Care Council encourages joint working by employers, students and higher education in delivering social work education and supports these partnerships with grants to help overcome difficulties working across and between organisations. However, as described in section 3.4.2, the curriculum for social work degrees does not appear to include specific education regarding work with end of life care patients and it seems as though any training in this area will be needed within either mandatory training or Continuous Personal and Professional Development opportunities during employment. Yet, there is no single source of funding support for social care employers for workforce development, education, training or assessment. For those who manage workforce development or the delivery of learning programmes to social care staff they are required to consider a number of sources of funding. In December 2008, the publication by Skills for Care of 'A Guide to resources & funding for workforce development in adult social care' has made access to funding slightly easier, both for trained social workers and for non-registered social care staff and their employers. The document can be found at www.skillsforcare.org.uk/funding

4.2.3 As part of a package of measures creating opportunities and supporting the long-term unemployed, the Chancellor has announced in the 2009 Budget a new scheme, *Care First*, offering 50,000 traineeships in **adult social care** for young people who have been out of work for twelve months, giving them the skills and experience they need for a career within **local authorities.**

4.2.4 For **health and social care staff working outside local councils and NHS organisations**; for example in private care homes and private domiciliary agencies, they are generally dependent on either their employer to fund courses for them or on self funding for courses. In 2001, the release by the Department of Health of *Building Capacity and Partnership in Care* launched a new Agreement between the statutory and independent sector and provided a framework for future working relationships between providers and commissioners locally. With regard to access to appropriate education for workers in the independent sector, a

recommendation was made that the commissioning of social care services should include contribution to the costs of establishing and maintaining an appropriately competent workforce.

Recommendation:

50. Commissioners of care provision from independent sector social care agencies should include the cost of education in end of life care within procurement contracts.

4.2.4.1 Skills for Care support NVQ training for adults' services in the private and voluntary sector via a Training Strategy Implementation Grant. This grant was set at £13m in 08/09 and is channelled through employer-led partnerships. Since there are NVQ courses in Palliative Care available in South East London, this source of funding may be an option to enable employers to send their staff in social care on an end of life care course.

4.2.5 **For all other staff not covered in sections 4.2.1 to 4.2.3; which would include prison staff, staff working in housing departments, and other support staff outside of the NHS**, there are no single sources of potential funding for end of life care education. Although it could be argued that these are generally Group C category staff and therefore require less access to education, they will still need a good basic grounding in the principles and practice of end of life care and be enabled to know when to refer or seek expert advice or information.

Recommendation:

51. Employers of this group of staff should ensure they have access to funding for education and training to obtain this knowledge. Where appropriate, this education could be provided by other more senior staff within their organisation who had attended more advanced training.

CONCLUSION AND NEXT STEPS

Key messages from the strategy

The publication of the national *End of Life Care Strategy* in July 2008 has raised the profile within England of the needs of both the people experiencing life threatening illness and the related services to care for them. The national strategy places the education and training of the whole health and social care workforce in end of life care as a priority to improve the experience of these people.

To date a broad range of education and training packages have been provided and some of them formally commissioned for delivery across South East London, but there is a clear need to move the organisation and commissioning of these towards greater coherence and consistency. Essentially, there needs to be assurance that education provision in end of life care will meet the training needs of the whole workforce in South East London across both the health and social care economy including primary care, the acute sector, care homes, local authority, independent sector and the voluntary sector.

Whilst there appears to be opportunities to achieve these aims through developments in new commissioning processes for London and the sector as well as new streams of funding for end of life care education, a transparent process for the allocation and securing of education funds and for the commissioning of palliative and end of life care education and training need to be developed and sustained for South East London. Commissioning of a programme of end of life care education and training should ideally occur at a sector level.

This end of life care education and training strategy for South East London has brought together both the national and local context to make recommendations that should enable the development of a workforce for the sector that is skilled and confident in end of life care. The main themes of this strategy are:

- For sector stakeholders to embrace opportunities from all *End of Life Care Strategy* national initiatives described within this document and link them with education commissioning and delivery within NHS London and this sector

- To have a collaborative, integrated & interprofessional approach to education and training

- For there to be a range of accredited and non-accredited options at all levels, with blended learning opportunities

- To encourage and develop opportunities for extensive workplace learning

- For education to have a focus on changing attitudes to death, dying and end of life care, so contributing to the development of a culture in which death will not be regarded as a failure, and a good death is seen as a successful care outcome

- For there to be the development of appropriate education and training packages to meet the needs of all staff across all care sectors, including care homes, acute, primary and voluntary sector service providers, ensuring that this content encompasses all aspects of the agreed end of life care pathway (*End of Life Care Strategy*, 2008)

- To promote a common approach to education programmes and courses that includes competency based education

- For core end of life care education and training to be free of charge to the South East London workforce themselves

- To achieve adequate and streamlined resourcing of training and development for the whole workforce

- For changes made to be based on the local intelligence described within this strategy regarding workforce training needs, workforce numbers and current education provision

Implementation of the strategy

In order to support the delivery of this Strategy and to realise the benefits for the South East London health and social care end of life care workforce, responsibility for its implementation will be needed at a number of levels - within individual provider and commissioning organisations, at locality level, at sector level, and at the level of NHS London.

The implementation of recommendations made within this strategy is primarily the responsibility of individual organisations. For easy reference, pages 103 to 123 provide a breakdown of recommendations against relevant categories of organisation.

However, it is recognised that some of the recommendations within the Strategy will be most effectively managed at a sector-wide level and that implementation of the Strategy at a local level will be served by the development of tools and guidelines that, were they to be developed locally, would result in the duplication of work across the sector.

To this end, it has been agreed that Marie Curie Delivering Choice Programme will host an Education and Training Strategy Implementation Board that will operate for the first year of implementation. The role of the Implementation Board will be:

- To champion the South East London End of Life Care Education and Training Strategy, its content and its implementation within the sector, within London and nationally, where appropriate
- To lead the implementation of the South East London End of Life Care Education and Training Strategy at a sector level
- To support and influence the implementation of the South East London End of Life Care Education and Training Strategy at a local level
- To consult with and incorporate the views of the Implementation Group and other stakeholders
- To review and update the Strategy in the light of decisions made by NHS London on the commissioning of education and training and other sector-wide developments
- To ensure that implementation is sufficiently developed to allow hand over to local EoLC Strategy Groups and the Palliative and End of Life Care Co-ordinating Group (PCCG) at the end of Year 1

Given the number of organisations involved in the implementation of the EoLC Education and Training Strategy, the Implementation Board will be formed as a small working group comprising single representation from the following sectors:

- Primary Care – End of Life Care (EoLC) Commissioning
- Primary Care Provider Arm – Workforce Lead
- Acute – Workforce Lead
- Social Care – Commissioning
- Social Care – Workforce Lead
- Voluntary care providers
- Independent care providers- care homes / domiciliary care
- Workforce for London
- Education Providers- KCL +/- Adult Education Colleges
- EoLC education & specialist palliative care (SPC) providers- Hospice
- EoLC education & care providers- Acute based SPC team
- Medical -professional representation
- Nursing & AHP – professional representation
- Social worker- professional representation

The Implementation Board will be supported and endorsed by an Implementation Group comprising a representative from all above listed sectors in each of the six localities and will number in the region of 60 members. As an alternative to this, and depending on the future of the group, the Palliative and End of Life Care Co-ordinating Group (PCCG) could also fulfil the remit of the Implementation Group. This will be decided by the Implementation Board in conjunction with the PCCG and local stakeholders.

The Implementation Group will engage with the proposals of the Implementation Board and input comments and suggestions to help direct the work of the Board and the implementation of the strategy from a local perspective. Given the size of the group, consultation will generally take place electronically.

It will be the role of the Marie Curie Delivering Choice Programme Project Team to work alongside the Implementation Board to support the development of the strategy at a local level, providing an interface between the Implementation Board and groups working locally to promote End of Life Care.

This will include, but not be limited to, reporting on the progress of the Board and the implementation of the Strategy at local EoLC Strategy Groups, engaging with key stakeholders at a local level and working with EoLC Strategy Groups and health and social care commissioners and workforce & education leads to develop local implementation plans.

The Strategy will be reviewed in twelve months from the date of its first circulation.

It is anticipated that, subject to local sector development, the Implementation Board will disband at the end of the first year of Strategy implementation and transfer responsibility of implementation in years two and three to localities in conjunction with a suitable sector-level group.

Implementation Impact Review

Success in implementation of this South East London End of Life Care Education and Training Strategy could be monitored in a number of ways including through:

- A repeat of the training needs analysis undertaken by the Marie Curie Delivering Choice programme prior to the creation of this strategy; with comparison of new information with the initial findings
- Comparison of pre- and post- implementation measurement of levels of end of life care client satisfaction
- Comparison of pre- and post implementation figures for inappropriate hospital transfers in end of life care
- Comparison of pre- and post implementation achievement of end of life care patients' preferences for care
- Comparison of pre- and post- implementation complaints audits for primary care, that reveal and quantify complaints relating to end of life care
- A repeat of the complaints audit for South East London acute trusts that was conducted by the sector's Palliative and End of Life Care Coordinating Group in January 2009. This audit required the gathering of information relating to end of life care complaints within individual acute trusts via a meeting with the PALS service and another meeting with the trust complaints manager. An audit template was used to collate data regarding numbers of complaints and, for

those relating to end of life care, the themes that emerged. An overview of the results can be seen below in Table 8.

Deciding on the methods and scope of the Impact Review, to be held at the end of the first year of implementation, will be the responsibility of the Implementation Board.

Table 8: Audit of acute trust complaints relating to end of life care, April 2007 – March 2008

	Hospital 1	**Hospital 2**	**Hospital 3**	**Hospital 4**	**Hospital 5**	**Hospital 6**
Number of complaints- April 07- March 08	941	919	525	316	297	351
Weighted complaints per bed per year	1.08	1.14	1.16	0.76	0.76	0.84
Number of complaints per bed per year	0.93	0.98	1.00	0.65	0.65	0.72
Number of complaints referred to the Health Care Commission April 07- March 08	27	34	13	11	3	9
% of complaints referred to the Health Care Commission that could relate to end of life care	2.8%	18%	Unspecified	18%	66%	33%
Themes of complaints related to end of life care	Lack of Nursing Care Lack of Medical Care Attitude of Nurses Lack of Information Poor Communication					

RECOMMENDATIONS FOR CATEGORIES OF ORGANISATION

Recommendations have been broken down by types of organisation in the following categories:

Please note that some organisations may have more than one category that is relevant to them.

Overarching Recommendations

1. There should be widespread acknowledgement that all Specialist Palliative Care Teams are and should be an educational resource for generalist end of life health and social care providers (Recommendation 1).

2. If options 3 or 4 adopted (Fig. 11):
   Although the alliances or individual PCTs may play some part in decision making regarding the commissioning of palliative and end of life care education and training, it remains more logical to focus this work at sector level and this should be the approach (Recommendation 45).

3. If options 3 or 4 adopted (Fig. 11):
   If palliative and end of life care education and training commissioning for South East London became the responsibility of SELACU, a reference group made up of clinicians and educationalists would be required to inform their decision making. The existing South East London Palliative and End of Life Care Coordinating Group, which is managed currently by the South East London Cancer Network, could provide this expertise (Recommendation 46).

4. If options 3 or 4 adopted (Fig 11):
   The maintenance of an End of Life Care Clinical Network for South East London is strongly recommended since, as well as other components of commissioning such as workforce development and service quality measurement, palliative and end of life care education and training commissioning would be best approached at a sector level (Recommendation 47).

Other

1. Employers of staff not discussed in this strategy (including prison staff, staff working in housing departments, and other support staff outside of the NHS) should ensure they have access to funding for education and training to obtain this knowledge. Where appropriate, this education could be provided by other more senior staff within their organisation who had attended more advanced training (Recommendation 51).

Recommendations for Healthcare Commissioners, e.g. PCTs

1. Primary Care Trusts and care providers within South East London should implement the national end of life care Quality Markers and Measures (2009) that are relevant to them (Recommendation 3).

2. Primary Care Trusts and other relevant bodies should encourage NHS London to adopt the national end of life care Quality Markers and Measures (2009) that are relevant to them (Recommendation 4).

3. Primary Care Trusts and local authorities should ensure that, when commissioning care packages for people in need of end of life care, the care agency guarantees its workers have the necessary knowledge, skills and attitudes to do the job. This requirement should be made explicit within contracts (Recommendation 10).

4. Where care packages are sub-contracted to independent provider organisations their workers should also have accessed relevant end of life care training packages from local expert education and training providers (Recommendation 11).

5. Smaller domiciliary care employers should receive support in understanding the educational needs of their staff and how they can find appropriate end of life care development and training. This might be achieved through dialogues between service commissioners and the service agency in their contracting process (Recommendation 13).

6. Organisations in South East London, such as Primary Care Trusts, who commission care from private care agencies and care homes for adult patients who may develop a need for end of life care, should require from them a workforce that is appropriately trained in end of life care (Recommendation 17).

7. The education needs of and training resources for informal carers in end of life care should be considered in a separate piece of work in close consultation with existing relevant User Partnership Groups within South East London and with links to the work of Omega / Caring with Confidence (Recommendation 23).

8. As recommended in the national End of Life Care Strategy, Primary Care Trusts should develop local strategies for promoting public awareness with regard to issues around death, dying and end of life care (Recommendation 24).

9. Given the importance of raising standards in the quality of end of life care, commissioning plans should enable health and social care workers to receive core end of life care education and training without having to self-fund (Recommendation 37).

10. Given the unfavourable findings relating to care home staff skills in end of life care provision as described the National Audit Office (NAO) *Report on End of Life Care* (2008), Primary Care Trusts should support with funding the care home proposals set out by the Marie Curie Delivering Choice Programme in conjunction with St Christopher's Hospice (Recommendation 40).

11. Primary Care Trusts in South East London should ensure that the funding for education provided in relation to the national End of Life Care Strategy (Section 4.2.1.3.1) is fully spent on optimising access for both health AND social care staff to palliative and end of life care education and training (Recommendation 48).

12. Commissioners of care provision from independent sector social care agencies should include the cost of education in end of life care within procurement contracts (Recommendation 50).

Recommendations for NHS Healthcare Providers- including the London Ambulance Service, plus Out of Hour GP services

1. Primary Care Trusts and care providers within South East London should implement the national end of life care Quality Markers and Measures (2009) that are relevant to them (Recommendation 3).

2. All individual health and social care workers in South East London should be supported to determine their education and training needs in end of life care by referring to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009) (Recommendation 5).

3. All relevant health and social service managers in South East London should determine the education and training needs in end of life care of their staff by referring to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009) (Recommendation 6).

4. Employers should refer to this Workforce Group framework (Fig. 7 or End of Life Care Strategy, DOH, 2009) in determining which level of skill and knowledge a particular employee should attain (Recommendation 15).

5. Whether NHS staff are to receive Group B or Group C level training must be determined at an organisational level. Relevant minimal levels of training regarding end of life care should then be incorporated into the Knowledge and Skills frameworks for individual posts and access by the worker to relevant courses enabled (Recommendation 16).

6. Employers of and individuals in support roles (including such roles as caterers, porters, mortuary staff, housekeepers, drivers, grounds men, administrators and fundraising staff) will need to consider which end of life care competencies relate to the individual post holder and determine educational needs accordingly (Recommendation 21).

7. Organisations that employ and / or commission education for the end of life care workforce should ensure that training needs assessments are performed on a regular basis to inform the commissioning of programmes of education. This may form an annual review of end of life care training needs identified within staff appraisal systems (Recommendation 26).

8. Health and social care service managers in South East London should enable relevant members of their workforce to access learning opportunities via the Department of Health's e-learning for End of Life Care project but should also ensure they access other classroom based education in end of life care. Group A and Group B staff in particular should have access to end of life care education that includes transformative learning methods (Recommendation 27).

9. Given the prevalence of end of life patient contact within the health and social care workforce and the importance of education in the provision of high quality end of life care, it is strongly recommended that:

    - For all staff employed by caring organisations there should be a mandatory session on end of life care during employment induction
    - Groups A and B staff groups have access to and complete mandatory training in end of life care relevant to their role and exposure to this work. For some Group A staff this is already established through requirements for academic qualifications in palliative care when following particular career pathways
    - For Groups A and B staff members, and as recommended within the national End of Life Care Strategy, this training should cover as a minimum the following subjects:

communication skills, assessment and care planning, advance care planning and symptom management, as they relate to end of life care

- Group C staff members should at least have access to induction programmes that include training regarding the principles of end of life care (Recommendation 30)

10. For staff that have significant or sole responsibility for end of life care as part of their role, provision of adequate training, development and mentorship for them by appropriate specialist practitioners should form an explicit part of the professional accountability of these posts, as part of their job description and contract (Recommendation 32).

11. Providers of end of life care education, health and social care service managers, and education commissioners should work together to develop programmes that include practice education. Such opportunities should in particular be made available for Group B categories of staff (Recommendation 33).

12. Health and social care service managers should encourage relevant members of their workforce to attend courses that have an interdisciplinary approach. This may involve allowing the release of complete teams from clinical work to attend such training (Recommendation 35).

13. Social and health care provider organisations in both the statutory, voluntary and independent sectors should campaign for Primary Care Trusts to fully spend funding for education provided in relation to the national End of Life Care Strategy (Section 4.2.1.3.1) on the provision of end of life care education and training for their staff (Recommendation 49).

Recommendations for Specialist Palliative Care including Hospices

1. Primary Care Trusts and care providers within South East London should implement the national end of life care Quality Markers and Measures (2009) that are relevant to them (Recommendation 3).

2. All individual health and social care workers in South East London should be supported to determine their education and training needs in end of life care by referring to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009) (Recommendation 5).

3. All relevant health and social service managers in South East London should determine the education and training needs in end of life care of their staff by referring to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009) (Recommendation 6).

4. Employers should refer to this Workforce Group framework (Fig 7 or End of Life Care Strategy, DOH, 2009) in determining which level of skill and knowledge a particular employee should attain (Recommendation 15).

5. Employers of and individuals in support roles (including such roles as caterers, porters, mortuary staff, housekeepers, drivers, grounds men, administrators and fundraising staff) will need to consider which end of life care competencies relate to the individual post holder and determine educational needs accordingly (Recommendation 21).

6. Organisations that employ and / or commission education for the end of life care workforce should ensure that training needs assessments are performed on a regular basis to inform the commissioning of programmes of education. This may form an annual review of end of life care training needs identified within staff appraisal systems (Recommendation 26).

7. Health and social care service managers in South East London should enable relevant members of their workforce to access learning opportunities via the Department of Health's e-learning for End of Life Care project but should also ensure they access other classroom based education in end of life care. Group A and Group B staff in particular should have access to end of life care education that includes transformative learning methods (Recommendation 27).

8. Given the prevalence of end of life patient contact within the health and social care workforce and the importance of education in the provision of high quality end of life care, it is strongly recommended that:

    - For all staff employed by caring organisations there should be a mandatory session on end of life care during employment induction
    - Groups A and B staff groups have access to and complete mandatory training in end of life care relevant to their role and exposure to this work. For some Group A staff this is already established through requirements for academic qualifications in palliative care when following particular career pathways
    - For Groups A and B staff members, and as recommended within the national End of Life Care Strategy, this training should cover as a minimum the following subjects: communication skills, assessment and care planning, advance care planning and symptom management, as they relate to end of life care

- Group C staff members should at least have access to induction programmes that include training regarding the principles of end of life care (Recommendation 30)

9. Providers of end of life care education, health and social care service managers, and education commissioners should work together to develop programmes that include practice education. Such opportunities should in particular be made available for Group B categories of staff (Recommendation 33).

10. Health and social care service managers should encourage relevant members of their workforce to attend courses that have an interdisciplinary approach. This may involve allowing the release of complete teams from clinical work to attend such training (Recommendation 35).

11. Specialist Palliative Care professionals should acknowledge their expertise and importance in the delivery of palliative and end of life care education to the generalist workforce, ensuring that this role is prioritised in their work planning (Recommendation 39).

12. Social and health care provider organisations in both the statutory, voluntary and independent sectors should campaign for Primary Care Trusts to fully spend funding for education provided in relation to the national End of Life Care Strategy (Section 4.2.1.3.1) on the provision of end of life care education and training for their staff (Recommendation 49).

Recommendations for Local Authority Commissioners

1. Primary Care Trusts and local authorities should ensure that, when commissioning care packages for people in need of end of life care, the care agency guarantees its workers have the necessary knowledge, skills and attitudes to do the job. This requirement should be made explicit within contracts (Recommendation 10).

2. Where care packages are sub-contracted to independent provider organisations their workers should also have accessed relevant end of life care training packages from local expert education and training providers (Recommendation 11).

3. Smaller domiciliary care employers should receive support in understanding the educational needs of their staff and how they can find appropriate end of life care development and training. This might be achieved through dialogues between service commissioners and the service agency in their contracting process (Recommendation 13).

4. Organisations in South East London, such as Primary Care Trusts, who commission care from private care agencies and care homes for adult patients who may develop a need for end of life care, should require from them a workforce that is appropriately trained in end of life care (Recommendation 17).

5. Given the importance of raising standards in the quality of end of life care, commissioning plans should enable health and social care workers to receive core end of life care education and training without having to self-fund (Recommendation 37).

6. Commissioners of care provision from independent sector social care agencies should include the cost of education in end of life care within procurement contracts (Recommendation 50).

Recommendations for Local Authority Providers

1. Primary Care Trusts and care providers within South East London should implement the national end of life care Quality Markers and Measures (2009) that are relevant to them (Recommendation 3).

2. All individual health and social care workers in South East London should be supported to determine their education and training needs in end of life care by referring to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009) (Recommendation 5).

3. All relevant health and social service managers in South East London should determine the education and training needs in end of life care of their staff by referring to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009) (Recommendation 6).

4. Local authority and independent domiciliary care agencies should ensure their staff have received appropriate training in end of life care (Recommendation 12).

5. Employers should refer to this Workforce Group framework (Fig. 7 or End of Life Care Strategy, DOH, 2009) in determining which level of skill and knowledge a particular employee should attain (Recommendation 15).

6. Whether Local Authority staff are to receive Group B or Group C level training must be determined at an organisational level. Relevant minimal levels of training regarding end of life care should then be incorporated into the Knowledge and Skills frameworks for individual posts and access by the worker to relevant courses enabled (Recommendation 19).

7. Employers of and individuals in support roles (including such roles as caterers, porters, mortuary staff, housekeepers, drivers, grounds men, administrators and fundraising staff) will need to consider which end of life care competencies relate to the individual post holder and determine educational needs accordingly (Recommendation 21).

8. Organisations that employ and / or commission education for the end of life care workforce should ensure that training needs assessments are performed on a regular basis to inform the commissioning of programmes of education. This may form an annual review of end of life care training needs identified within staff appraisal systems (Recommendation 26).

9. Health and social care service managers in South East London should enable relevant members of their workforce to access learning opportunities via the Department of Health's e-learning for End of Life Care project but should also ensure they access other classroom based education in end of life care. Group A and Group B staff in particular should have access to end of life care education that includes transformative learning methods (Recommendation 27).

10. Given the prevalence of end of life patient contact within the health and social care workforce and the importance of education in the provision of high quality end of life care, it is strongly recommended that:

    - For all staff employed by caring organisations there should be a mandatory session on end of life care during employment induction
    - Groups A and B staff groups have access to and complete mandatory training in end of life care relevant to their role and exposure to this work. For some Group A staff this is already established through requirements for academic qualifications in palliative care when following particular career pathways

- For Groups A and B staff members, and as recommended within the national End of Life Care Strategy, this training should cover as a minimum the following subjects: communication skills, assessment and care planning, advance care planning and symptom management, as they relate to end of life care
- Group C staff members should at least have access to induction programmes that include training regarding the principles of end of life care (Recommendation 30)

11. Providers of end of life care education, health and social care service managers, and education commissioners should work together to develop programmes that include practice education. Such opportunities should in particular be made available for Group B categories of staff (Recommendation 33).

12. Health and social care service managers should encourage relevant members of their workforce to attend courses that have an interdisciplinary approach. This may involve allowing the release of complete teams from clinical work to attend such training (Recommendation 35).

13. Social and health care provider organisations in both the statutory, voluntary and independent sectors should campaign for Primary Care Trusts to fully spend funding for education provided in relation to the national End of Life Care Strategy (Section 4.2.1.3.1) on the provision of end of life care education and training for their staff (Recommendation 49).

Recommendations for the Independent Sector:
Voluntary sector providers (excluding hospices)

1. Primary Care Trusts and care providers within South East London should implement the national end of life care Quality Markers and Measures (2009) that are relevant to them (Recommendation 3).

2. All individual health and social care workers in South East London should be supported to determine their education and training needs in end of life care by referring to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009) (Recommendation 5).

3. All relevant health and social service managers in South East London should determine the education and training needs in end of life care of their staff by referring to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009) (Recommendation 6).

4. Local authority and independent domiciliary care agencies should ensure their staff have received appropriate training in end of life care (Recommendation 12).

5. Employers should refer to this Workforce Group framework (Fig. 7 or End of Life Care Strategy, DOH, 2009) in determining which level of skill and knowledge a particular employee should attain (Recommendation 15).

6. Independent sector organisations and teams providing care to end of life care patients in South East London should ensure their staff have access to and undertake appropriate training and providing them with the minimum level of knowledge and skills for their role (Recommendation 18).

7. Employers of and individuals in support roles (including such roles as caterers, porters, mortuary staff, housekeepers, drivers, grounds men, administrators and fundraising staff) will need to consider which end of life care competencies relate to the individual post holder and determine educational needs accordingly (Recommendation 21).

8. Organisations that employ and / or commission education for the end of life care workforce should ensure that training needs assessments are performed on a regular basis to inform the commissioning of programmes of education. This may form an annual review of end of life care training needs identified within staff appraisal systems (Recommendation 26).

9. Health and social care service managers in South East London should enable relevant members of their workforce to access learning opportunities via the Department of Health's e-learning for End of Life Care project but should also ensure they access other classroom based education in end of life care. Group A and Group B staff in particular should have access to end of life care education that includes transformative learning methods (Recommendation 27).

10. Given the prevalence of end of life patient contact within the health and social care workforce and the importance of education in the provision of high quality end of life care, it is strongly recommended that:

    - For all staff employed by caring organisations there should be a mandatory session on end of life care during employment induction
    - Groups A and B staff groups have access to and complete mandatory training in end of life care relevant to their role and exposure to this work. For some Group A staff this is already established through requirements for academic qualifications in palliative care when following particular career pathways

- For Groups A and B staff members, and as recommended within the national End of Life Care Strategy, this training should cover as a minimum the following subjects: communication skills, assessment and care planning, advance care planning and symptom management, as they relate to end of life care
- Group C staff members should at least have access to induction programmes that include training regarding the principles of end of life care (Recommendation 30)

11. For staff that have significant or sole responsibility for end of life care as part of their role, provision of adequate training, development and mentorship for them by appropriate specialist practitioners should form an explicit part of the professional accountability of these posts, as part of their job description and contract (Recommendation 32).

12. Providers of end of life care education, health and social care service managers, and education commissioners should work together to develop programmes that include practice education. Such opportunities should in particular be made available for Group B categories of staff (Recommendation 33).

13. Health and social care service managers should encourage relevant members of their workforce to attend courses that have an interdisciplinary approach. This may involve allowing the release of complete teams from clinical work to attend such training (Recommendation 35).

14. Social and health care provider organisations in both the statutory, voluntary and independent sectors should campaign for Primary Care Trusts to fully spend funding for education provided in relation to the national End of Life Care Strategy (Section 4.2.1.3.1) on the provision of end of life care education and training for their staff (Recommendation 49).

Recommendations for the Independent Sector:
Care Homes and Domiciliary Care Home Providers

1. Primary Care Trusts and care providers within South East London should implement the national end of life care Quality Markers and Measures (2009) that are relevant to them (Recommendation 3).

2. All individual health and social care workers in South East London should be supported to determine their education and training needs in end of life care by referring to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009) (Recommendation 5).

3. All relevant health and social service managers in South East London should determine the education and training needs in end of life care of their staff by referring to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009) (Recommendation 6).

4. Local authority and independent domiciliary care agencies should ensure their staff have received appropriate training in end of life care (Recommendation 12).

5. Smaller domiciliary care employers should receive support in understanding the educational needs of their staff and how they can find appropriate end of life care development and training. This might be achieved through dialogues between service commissioners and the service agency in their contracting process (Recommendation 13).

6. Employers should refer to this Workforce Group framework (Fig. 7 or End of Life Care Strategy, DOH, 2009) in determining which level of skill and knowledge a particular employee should attain (Recommendation 15).

7. Independent sector organisations and teams providing care to end of life care patients in South East London should ensure their staff have access to and undertake appropriate training and providing them with the minimum level of knowledge and skills for their role (Recommendation 18).

8. Whether Social Care staff are to receive Group B or Group C level training must determined at an organisational, local authority or Primary Care Trust level. Relevant minimal levels of training regarding end of life care should then be incorporated into the Knowledge and Skills frameworks for individual posts and access for the worker to relevant courses enabled (Recommendation 20).

9. Employers of and individuals in support roles (including such roles as caterers, porters, mortuary staff, housekeepers, drivers, grounds men, administrators and fundraising staff) will need to consider which end of life care competencies relate to the individual post holder and determine educational needs accordingly (Recommendation 21).

10. Organisations that employ and / or commission education for the end of life care workforce should ensure that training needs assessments are performed on a regular basis to inform the commissioning of programmes of education. This may form an annual review of end of life care training needs identified within staff appraisal systems (Recommendation 26).

11. Health and social care service managers in South East London should enable relevant members of their workforce to access learning opportunities via the Department of Health's e-learning for End of Life Care project but should also ensure they access other classroom based education in end of life care. Group A and Group B staff in particular

should have access to end of life care education that includes transformative learning methods (Recommendation 27).

12. Given the prevalence of end of life patient contact within the health and social care workforce and the importance of education in the provision of high quality end of life care, it is strongly recommended that:

    - For all staff employed by caring organisations there should be a mandatory session on end of life care during employment induction
    - Groups A and B staff groups have access to and complete mandatory training in end of life care relevant to their role and exposure to this work. For some Group A staff this is already established through requirements for academic qualifications in palliative care when following particular career pathways
    - For Groups A and B staff members, and as recommended within the national End of Life Care Strategy, this training should cover as a minimum the following subjects: communication skills, assessment and care planning, advance care planning and symptom management, as they relate to end of life care
    - Group C staff members should at least have access to induction programmes that include training regarding the principles of end of life care (Recommendation 30)

13. For staff that have significant or sole responsibility for end of life care as part of their role, provision of adequate training, development and mentorship for them by appropriate specialist practitioners should form an explicit part of the professional accountability of these posts, as part of their job description and contract (Recommendation 32).

14. Providers of end of life care education, health and social care service managers, and education commissioners should work together to develop programmes that include practice education. Such opportunities should in particular be made available for Group B categories of staff (Recommendation 33).

15. Health and social care service managers should encourage relevant members of their workforce to attend courses that have an interdisciplinary approach. This may involve allowing the release of complete teams from clinical work to attend such training (Recommendation 35).

16. Social and health care provider organisations in both the statutory, voluntary and independent sectors should campaign for Primary Care Trusts to fully spend funding for education provided in relation to the national End of Life Care Strategy (Section 4.2.1.3.1) on the provision of end of life care education and training for their staff (Recommendation 49).

Recommendations for Education Commissioners, including within PCTs, Local Authorities & other organisations

1. Education commissioners and providers should aim to create and deliver education and training packages which allow staff from different settings to learn together (Recommendation 2).

2. Education commissioners in South East London should ensure that there is access to a full range of end of life care education and training courses, in line with the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009).and the knowledge and skills needed to deliver the end of life care pathway (national End of Life Care Strategy, 2008) (Recommendation 8).

3. Education commissioners and providers should ensure education and training in palliative and end of life care is available to domiciliary care workers as a priority (Recommendation 9).

4. To ensure that local health and social care services are delivering culturally sensitive end of life care relevant to local populations, the emphasis within education programmes should be for practitioners to ask end of life care patients their preferences, regarding their cultural and other needs (Recommendation 14).

5. Commissioners and providers of education and training should agree to the design and delivery of multi-professional, multi-agency training programmes based not only on the national competencies and end of life care pathway, but with particular consideration of the findings of Marie Curie Delivering Choice Programme Training Needs Assessment for South East London (Recommendation 25).

6. Organisations that employ and / or commission education for the end of life care workforce should ensure that training needs assessments are performed on a regular basis to inform the commissioning of programmes of education. This may form an annual review of end of life care training needs identified within staff appraisal systems (Recommendation 26).

7. Education commissioners in South East London should ensure that end of life care courses for at least staff Groups A and B include transformative learning methods (Recommendation 29).

8. Given the prevalence of end of life patient contact within the health and social care workforce and the importance of education in the provision of high quality end of life care, it is strongly recommended that:

    - For all staff employed by caring organisations there should be a mandatory session on end of life care during employment induction
    - Groups A and B staff groups have access to and complete mandatory training in end of life care relevant to their role and exposure to this work. For some Group A staff this is already established through requirements for academic qualifications in palliative care when following particular career pathways
    - For Groups A and B staff members, and as recommended within the national End of Life Care Strategy, this training should cover as a minimum the following subjects: communication skills, assessment and care planning, advance care planning and symptom management, as they relate to end of life care
    - Group C staff members should at least have access to induction programmes that include training regarding the principles of end of life care (Recommendation 30)

9. Education commissioners and providers should consider options for the creation of 'train the trainer' programmes to provide delivery of basic palliative and end of life care education through cascade principles of training (Recommendation 31).

10. Providers of end of life care education, health and social care service managers, and education commissioners should work together to develop programmes that include practice education. Such opportunities should in particular be made available for Group B categories of staff (Recommendation 33).

11. Education commissioners in South East London should ensure that palliative and end of life care courses include opportunities for interdisciplinary learning (Recommendation 36)

12. Given the importance of raising standards in the quality of end of life care, commissioning plans should enable health and social care workers to receive core end of life care education and training without having to self-fund (Recommendation 37).

13. When negotiating the commissioning of palliative and end of life care education programmes, commissioners and education providers should include the cost of backfill for clinicians acting as educators (Recommendation 38).

14. Education leads, commissioners and providers should ensure that opportunities to submit bids for additional CPPD funding are undertaken to enable an increase in access of their staff and staff from related services to end of life care education and training (Recommendation 41).

15. If options 1 or 2 adopted (Fig. 11)
    Education leads and commissioners within NHS organisations as well as education providers should ensure that the newly formed Education Commissioning Hub, if procuring palliative and end of life care education, engages with the full range of relevant education providers in South East London as indicated via the 2007-8 course mapping in section 3.4.2 (Recommendation 43).

16. If options 1 or 2 adopted (Fig. 11):
    If procuring palliative and end of life care education and training themselves, education leads and commissioners within NHS organisations should engage with the full range of relevant education providers in South East London (as indicated via the 2007-8 course mapping in section 3.4.2) (Recommendation 44).

Recommendations for Palliative & End of Life Care Education Providers

1. Education commissioners and providers should aim to create and deliver education and training packages which allow staff from different settings to learn together (Recommendation 2).

2. All South East London organisations that deliver end of life care education and training should refer to the 'core competencies and principles for health and social care workers working with adults at end of life' (DOH, 2009) when determining educational programmes, course curricula, outcomes and in designing course material. They should ensure that their courses cover the knowledge, skills and attitudes required for health and social care staff to deliver all aspects of the end of life pathway of care (national End of Life Care Strategy, 2008) (Recommendation 7).

3. Education commissioners and providers should ensure education and training in palliative and end of life care is available to domiciliary care workers as a priority (Recommendation 9).

4. To ensure that local health and social care services are delivering culturally sensitive end of life care relevant to local populations, the emphasis within education programmes should be for practitioners to ask end of life care patients their preferences, regarding their cultural and other needs (Recommendation 14).

5. Palliative and end of life care education providers should consider developing their education programmes to include the needs of support workers that come into contact with end of life care patients (Recommendation 22).

6. Commissioners and providers of education and training should agree to the design and delivery of multi-professional, multi-agency training programmes based not only on the national competencies and end of life care pathway, but with particular consideration of the findings of Marie Curie Delivering Choice Programme Training Needs Assessment for South East London (Recommendation 25).

7. Providers of end of life care education in South East London should ensure that their courses include both didactic and transformative learning methods (Recommendation 28).

8. Education commissioners and providers should consider options for the creation of 'train the trainer' programmes to provide delivery of basic palliative and end of life care education through cascade principles of training (Recommendation 31).

9. Providers of end of life care education, health and social care service managers, and education commissioners should work together to develop programmes that include practice education. Such opportunities should in particular be made available for Group B categories of staff (Recommendation 33).

10. Providers of end of life care education should ensure that their education programmes include opportunities for interdisciplinary learning and that these courses include opportunities for team based clinical case analysis and learning (Recommendation 34).

11. When negotiating the commissioning of palliative and end of life care education programmes, commissioners and education providers should include the cost of backfill for clinicians acting as educators (Recommendation 38).

12. Education leads, commissioners and providers should ensure that opportunities to submit bids for additional CPPD funding are undertaken to enable an increase in access

of their staff and staff from related services to end of life care education and training (Recommendation 41).

13. Education providers should have available fully costed education programmes, so that incidental funding opportunities can be actioned promptly (Recommendation 42).

14. If options 1 or 2 adopted (Fig. 11)
    Education leads and commissioners within NHS organisations as well as education providers should ensure that the newly formed Education Commissioning Hub, if procuring palliative and end of life care education, engages with the full range of relevant education providers in South East London as indicated via the 2007-8 course mapping in section 3.4.2 (Recommendation 43).

Appendix 1:
Marie Curie Delivering Choice Programme's Education and Training work stream members

Name	Position	Organisation
Tim Jackson	SELCN Nurse Director	SEL Cancer Network
Kath McDonnell	Palliative & EoLC Programme Manager	SEL Cancer Network
Donna Kinnair	Senior Commissioner	Southwark PCT
Gill Black	Senior Commissioner	Lambeth PCT
Paul White	Senior Commissioner	Bexley Care Trust
Yee Cho	PCT Commissioner	Bromley PCT
Julie Richardson	GP Education Rep	Greenwich Teaching PCT
David Oliviere	Director of Training & Education	St Christopher's Hospice
Claire Plant	Team Leader/ Palliative Care Team	Queen Mary's Sidcup
Dr Elizabeth Jones	Consultant in Palliative Medicine	Queen Mary's Sidcup
Deirdre Peters	Team Leader/ Palliative Care Team	Greenwich
Dr Polly Edmonds	Consultant in Palliative Medicine	Kings College Hospital
Rachel Burman	Consultant in Palliative Care	Kings College Hospital
Nikki Le Prevost	Clinical Educator for Palliative Care	EllenorLions Hospice
Anneyce Knight	Senior Nursing Lecturer	University
Mary Pennell	Lecturer in Palliative Care	Kings College London
Joanne Smith	Clinical Educator	LAS / Out of Hours Services
Vicky Robinson	Nurse Consultant	Guys and St Thomas's Hospital
Angela Grainger (Chair)	Assistant Director of Nursing - Education & Research	Kings College Hospital NHS Foundation Trust
Christine Bryan	Nurse Lead Adults and Older People	Southwark PCT
Sharon Wiltshire	Temporary Brokerage Team Manager	Lewisham Council
Grace Rodney	Organisational development training manager Adult Health and Social Care	Lewisham Social Services
Merle Long	Interim Head of Health & Interventions	Borough of Bexley
Dr Cathy Burton	GP, Macmillan GP Facilitator	Lambeth PCT & SEL Cancer Network
Dr Winnie Kwan	GP	Bexley PCT
Dr Phillippa Taylor	GP	Bromley PCT
Diane Gayle	BME Group Representative	Bexley Care Trust
Carlene Perris	Allied Health Professional Representative	SEL Cancer Network
Liz Bryan	Lecturer, Practitioner	St Christopher's Hospice
Penny Hansford	Director of Training & Education	St Christopher's Hospice
Jackie Maskell	Associate Director of Adult Services	Lewisham PCT
Dominic Stanton	Assistant Director of Adult & Community Care	Borough of Lambeth
Serena Cooper	Clinical Dean	Kings College Hospital
Lorraine Robinson	Palliative Care Programme Lead, KCH	Kings College, London
Alison McLaughlin	Head of Adult & Performance Service Development	Bexley Council
Susanna Shouls	Programme Manager, End of Life Care	Modernisation Initiative
Nicola Robinson	GP	Lewisham
David Scott	SELCN Patient representative	

Appendix Two: References

NB. All documents published by the Department of Health can be found at their website www.dh.gov.uk

Alsop A & Ryan S (1996): *Making the Most of Fieldwork Education: A Practical Approach.* London: Chapman & Hall.

Barr, H. (2000) *Inter-professional Education: 1997-2000. A Review*. United Kingdom Central Council of Nursing, Midwifery and Health Visiting

Brendel, W. (2005), Columbia University, Presented at the Sixth International Transformative Learning Conference, Michigan State University, Oct. 6-9, 2005. Available at: http://www.williambrendel.com/uploads/On_Transformative_Learning_and_End_of_Life_Discussions.pdf

Carpenter, J. (1995) Doctors and Nurses: Stereotype and stereotype change in inter-professional education. *Journal of Inter-professional Care* 9: 151-162

Carpenter, J. and Hewstone, M. (1996) Shared learning for doctors and social workers. *British Journal of Social Work* 26: 239-257

Childs, S. et al (2005) Effective e-learning for health professionals and students—barriers and their solutions. A systematic of the literature—findings from the HeXL project. *Health Information and Libraries Journal*, 22 (Suppl. 2), pp.20–32

Department of Health *Building capacity and partnership in care*: DoH, 2001

Department of Health. *Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own.* DoH, June 2008

Department of Health. *End of Life Care Strategy: promoting high quality care for adults at the end of life. London.* DoH, July 2008

Department of Health. *End of Life Care Strategy: Quality Markers and Measures for End of Life Care. London.* DoH, June 2009

Department of Health. *Modernising Nursing Careers: Setting the Direction*. DoH, September 2006

Department of Health. *The NHS Cancer Plan: A plan for investment, a plan for reform*. DoH, September 2000

Department of Health. *Working Together—Learning Together: A Framework for Lifelong Learning in the NHS.* DoH, 2001

Department of Health. *Working to Put People First: The Strategy for the Adult Social Care Workforce in England.* DoH, April 2009

Department of Health, Skills for Health, Skills for Care, NHS End of Life Care Programme. *Common core competences and principles for health and social care workers working with adults at the end of life*. DoH, June 2009

Gomes B and Higginson I (2008) Where people die [1974 2030]: past trends, future projections and implications for care. *Palliative Medicine* 22: 33-41

House of Lords Health Committee. *Modernising Medical Careers: Third Report of Session 2007–08*. London: House of Lords Health Committee, April 2008

Kane, J.R., Hellsten, M.B., & Coldsmith, A. (2004). Human suffering: The need for relationship-based research in pediatric end-of-life care. *Journal of Pediatric Oncology Nursing*, 21(3), 180-185.

Mallory, J. (2003) The Impact of a Palliative Care Educational Component on Attitudes Toward Care of the Dying in Undergraduate Nursing Students. *Journal of Professional Nursing,* Vol. 19, pp 305-312

McKinsey & Co (2007), Development of an Education Commissioning Regime for NHS London – Nov 2007 presentation, slide 4; unpublished

National Audit Office. *End of Life Care: Report by the Comptroller and Auditor General- HC 1043 Session 2007- 2008*. NAO, November 2008

NHS London (2007) *Development of an Education Commissioning System for NHS London: a report*. NHS London

NHS London. *Workforce for London- a Strategic Framework*. NHS London, September 2008

O'Neill, B., Wyness, A., McKinnon, S. and Granger, P. (2000) *Partnership, Collaboration and Course Design: An emerging model of inter-professional education.* Not published

The SE London Palliative & End of Life Care Network. *SE London Education Palliative & EOLC Strategy 2007-9;* unpublished

Professor the Lord Darzi of Denham. *High Quality Care for All: NHS Next Stage Review Final Report*. DoH, June 2008

Rabow MW et al (2003) Patient perceptions of an outpatient palliative care intervention: 'it had been on my mind before, but I did not know how to start talking about death...' *Journal of Pain and Symptom Management* 26(5): 1010–15

Rees, I (1999) *Supplementary Report on Domiciliary Care for Modernising the Social Care Workforce: The First National Training Strategy for England*. TOPSS / DoH, 2000

Skills for Care (2008) *A Guide to resources & funding for workforce development in adult social care*. Skills for Care

Skills for Health (2008) *Staff Learning and Development Funding: Guidance for Employers*. Skills for Health

Steinhauser KE, et al (2001) Preparing for the end of life: preferences of patients, families, physicians and other care givers*. Journal of Pain and Symptom Management* 22(3): 727–37

Unknown author (2009) *Strengthening Commissioning in South East London: Summary of Outline Business Case for the Sector Commissioning Vehicle.* Unpublished

Appendix 3- Extract from 'Common core competences and principles for health and social care workers working with adults at the end of life' (DoH, 2009)

The competences

Occupation- and profession-specific competences, which may also cover relevant overarching values and knowledge, exist for workers across health, social care and other sectors. However these will need to be built upon for times when they are working with people approaching, or at the end of their lives.

Expectations around the four key areas will vary according to circumstances. They should be interpreted and applied to the particular role and circumstances of the worker, or workers. They should link appropriately to the level required by service standards and the level the worker would normally be expected to perform at when providing the service, in conjunction with the degree of involvement in the individual's End of life care (EoLC). Overarching values and knowledge competences as they relate to EoLC should also be understood and demonstrated by all workers.

The competences may be used as a freestanding framework, but are also designed to be referenced to other occupational standards and frameworks, such as the Knowledge and Skills Framework, National Occupational Standards for Heath and Social Care, National Workforce Competences (Skills for Health) and the Qualifications and Credit Framework (QCF[3]) which will replace NVQs. Further work is planned to group the competences as basic, intermediate and specialist to allow local flexibility. Some work has already begun in making these links, and can be accessed via www.endoflifecareforadults.nhs.uk. This work will continue, and as progress is made further guidance and tools will be added.[4]

The main dimensions for each of the competence areas are as follows:

1. Communication Skills

a. In relation to EoLC, communicate with a range of people on a range of matters in a form that is appropriate to them and the situation.
b. Develop and maintain communication with people about difficult and complex matters or situations related to EoLC.
c. Present information in a range of formats, including written and verbal, as appropriate to the circumstances.
d. Listen to individuals, their families and friends about their concerns related to the end of life and provide information and support.
e. Work with individuals, their families and friends in a sensitive and flexible manner, demonstrating awareness of the impact of death, dying and bereavement, and recognising that their priorities and ability to communicate may vary over time.

2. Assessment and Care Planning

a. Understand the range of assessment tools, and ways of gathering information, and their advantages and disadvantages.
b. Assess pain and other symptoms using assessment tools, pain history, appropriate physical examination and relevant investigation.

c. Undertake/contribute to multi-disciplinary assessment and information sharing.
d. Ensure that all assessments are holistic, including:
- Background information
- Current physical health and prognosis
- Social/occupational well-being
- Psychological and emotional well-being
- Religion and/or spiritual well-being, where appropriate
- Culture and lifestyle aspirations, goals and priorities
- Risk and risk management
- The needs of families and friends, including carer's assessments.

e. Regularly review assessments to take account of changing needs, priorities and wishes, and ensure information about changes is properly communicated.

3. Symptom management, maintaining comfort and well being

a. Be aware that symptoms have many causes, including the disease itself, its treatment, a concurrent disorder, including depression or anxiety, or other psychological or practical issues.
b. Understand the significance of the individual's own perception of their symptoms to any intervention.
c. Understand that the underlying causes of a symptom will have an impact upon how care should be delivered.
d. Understand the range of therapeutic options available, including drugs, hormone therapy, physical therapies, counselling or other psychological interventions, complementary therapies, surgery, community or practical support.
e. In partnership with others, including the individual, their family and friends, develop an EoLC plan which balances disease-specific treatment with other interventions and support that meet the needs of the individual.
f. In partnership with others, implement, monitor and review the EoLC plan.
g. Awareness of cultural issues that may impact on symptom management.

4. Advance Care Planning

a. Demonstrate awareness and understanding of Advance Care Planning, and the times at which it would be appropriate.
b. Demonstrate awareness and understanding of the legal status and implications of the Advance Care Planning process in accordance with the provisions of the Mental Capacity Act 2005.
c. Show understanding of Informed Consent, and demonstrate the ability to give sufficient information in an appropriate manner.
d. Use effective communication skills when having Advance Care Planning discussions as part of ongoing assessment and intervention.
e. Work sensitively with families and friends to support them as the individual decides upon their preferences and wishes during the Advance Care Planning process.
f. Where appropriate, ensure that the wishes of the individual, as described in an Advance Care Planning statement, are shared (with permission) with other workers.

g. When appropriate, know what the Advance Care Planning statement contains, and how this will impact upon an individual's care delivery.

5. Overarching values and knowledge

a. In the context of EoLC, understanding and knowledge of:
- One's own professional/role boundaries
- Legal and ethical issues - adherence to legislation and advisory guidance around e.g. Mental Capacity Act and the Mental Health Act
- Professional codes of practice or conduct, and their impact on practice
- The role/contribution of other workers and organisations to ensure leadership commitment and innovation
- The impact of one's own beliefs on practice
- Approaches to risk assessment, management and taking
- Approaches to and theories of change, loss and bereavement
- Social models of care, and person-centred approaches.

b. Person-centred practice that recognises the circumstances, concerns, goal, beliefs and cultures of the individual, their family and friends, and acknowledges the significance of spiritual, emotional and religious support and the diversities in these regards that there might be between family or social group members.

c. Practice that is sensitive to the support needs of family and friends, including children and young people, both as part of EoLC, and following bereavement.

d. Awareness of the importance of contributing to evaluation and change of services, participating as appropriate, and of involving the people who use them in that process.

e. Taking responsibility for one's own learning and continuing professional development, and contributing to the learning of others.

Appendix 4: South East London Specialist Palliative Care (SPC) Workforce Numbers, 2007 (source: NCPC)

South East London SPC Nursing Workforce Data

Please note: all data is as reported in the completed cancer network data returns.

Nursing Proforma	
HD	373,866
FTE	303,200
HD/FTE ratio	0.811

POST / GRADE / AGENDA FOR CHANGE BANDING	FULL TIME EQUIVALENT (FTE)						FTE TOTAL**	Nos of staff in post (SIP)*	Funded Establishment (FTE)	Vacancies (FTE)	No aged over 60	Vacancies / FTE	Estimated Headcount*	No over 60 / Estimated Headcount
	VOLUNTARY SECTOR			NHS										
PERMANENT STAFF	Hospital Support	Community	SPC Unit	Hospital Support	Community	SPC Unit								
Band 8a Band 8b Band 8c	0.0 0.0 0.0	6.6 0.9 0.1	0.3 0.0 0.1	5.5 0.0 1.0	4.0 0.0 0.0	0.0 0.0 0.0	16.4 0.9 1.2	12 0 1	10.5 0.0 1.3	1.0 1.0 1.0	0 0 1			
Senior Nurses (Total bands 8a-8c)	**0.0**	**7.6**	**0.4**	**6.5**	**4**	**0.0**	**18.5**	**13**	**11.8**	**3**	**1**	**13.9%**	**23**	**4.4%**
Grade I/H Band 7	**3.0**	**34.4**	**7.6**	**8**	**14**	**0.0**	**67.0**	**38**	**30.5**	**3.9**	**5**	**5.5%**	**83**	**6.1%**
Grade F/G Band 5/6	**0.0**	**0.7**	**8.4**	**0.0**	**0.0**	**0.0**	**9.1**	**18**	**6.1**	**0**	**2**	**0.0%**	**11**	**17.9%**
Grade D/E Band 5	**0.0**	**1.9**	**43.6**	**0.0**	**0.0**	**0.0**	**45.5**	**92**	**20.3**	**5.9**	**7**	**11.4%**	**56**	**12.5%**
Grades A-C Bands 2/3/4	**0.0**	**0**	**37.2**	**0.0**	**0.0**	**0.0**	**37.2**	**64**	**19.6**	**0.7**	**6**	**1.7%**	**46**	**13.1%**
Total	**3.0**	**44.6**	**97.1**	**14.5**	**18.0**	**0.0**	**177.2**	**225**	**88.4**	**13.4**	**21**			

* No. of SIP reported by the survey was variable and so the proportion of nurses aged over 50 was calculated using an estimated headcount figure calculated by nurse participation rate stated in NHS IC Census 2006

** Calculated FTE totals differ from those reported, therefore only the reported totals will be displayed here

POST	BAND	FULL TIME EQUIVALENT (FTE)						FTE TOTAL	Nos of staff in post (SIP)	Funded Establishment (FTE)	Vacancies (FTE)	No aged over 60	Vacancies / FTE	No. aged 50+ as a proportion of SIP*	No aged 50+ as a proportion of FTE
		VOLUNTARY SECTOR			NHS										
PERMANENT STAFF		Hospital Support	Community	SPC Unit	Hospital Support	Community	SPC Unit								
Bereavement support staff / counsellors	Band 6		0.0	0.9				0.9							
	Band 5		0.5	2.3				2.8							
	Not specified		0.8	0.6				1.3							
	Total	**0.0**	**1.3**	**3.8**	**0.0**	**0.0**	**0.0**	**5.0**	**0**	**0.0**	**0.0**	**0**	**0.0%**	**0.0%**	**0.0%**
Chaplains / faith healers (authorised and appointed)	Band 6		0.6					0.6							
	Band 7		0.7					0.7							
	Total	**0.0**	**1.3**	**0.0**	**0.0**	**0.0**	**0.0**	**1.3**	**0**	**0.0**	**0.0**	**0**	**0.0%**	**0.0%**	**0.0%**
Complementary Therapists	Band 6		0.3	0.8				1.1	5	0.2					
	Band 5		0.9	0.6				1.6	3	0.1					
	Total	**0.0**	**1.2**	**1.4**	**0.0**	**0.0**	**0.0**	**2.6**	**8**	**0.3**	**0.0**	**0**	**0.0%**	**0.0%**	**0.0%**
Counsellors	Band 6		0.2					0.2							
	Total	**0.0**	**0.2**	**0.0**	**0.0**	**0.0**	**0.0**	**0.2**	**0**	**0.0**	**0.0**	**0**	**0.0%**	**0.0%**	**0.0%**
Dieticians	Band 7			0.3	0.5	1.5		2.3	3	1					
	Total	**0.0**	**0.0**	**0.3**	**0.5**	**1.5**	**0.0**	**2.3**	**3**	**1**					
Lymphoedema therapists	Band 6		1.0					1.0							
	Band 7		0.6					0.6							
	Total	**0.0**	**1.6**	**0.0**	**0.0**	**0.0**	**0.0**	**1.6**	**0**	**0.0**	**0.0**	**0**	**0.0%**	**0.0%**	**0.0%**
MDT Co-ordinators	Band 4				0.1			0.1							
	Band 5			0.9				0.9							
	Band 7		0.1	0.1				0.2	1	0.2		1			
	Total	**0.0**	**0.1**	**1.0**	**0.1**	**0.0**	**0.0**	**1.2**	**1**	**0.2**	**0.0**	**1**	**0.0%**	**100.0%**	**83.3%**
Occupational therapists	Band 6		0.4	0.2				0.6	1	0.2					
	Band 7		0.2	0.4				0.5	1	0.5					
	Total	**0.0**	**0.6**	**0.6**	**0.0**	**0.0**	**0.0**	**1.1**	**2**	**0.7**	**0.0**	**0**	**0.0%**	**0.0%**	**0.0%**
Other staff	Band 5		0.6					0.6							
	Band 6		0.7	0.4	0.6			1.6							
	Total	**0.0**	**1.2**	**0.4**	**0.6**	**0.0**	**0.0**	**2.2**	**0**	**0.0**	**0.0**	**0**	**0.0%**	**0.0%**	**0.0%**
Pharmacists	Band 7			0.4				0.4							
	Band 8 and above	1.0						1.0							
	Total	**1.0**	**0.0**	**0.4**	**0.0**	**0.0**	**0.0**	**1.4**	**0**	**0.0**	**0.0**	**0**	**0.0%**	**0.0%**	**0.0%**
Physio-therapists	Band 6		0.5	0.3				0.9	3	0.9		1			
	Band 7		0.3	0.5				0.8	2	0.9					
	Total	**0.0**	**0.8**	**0.9**	**0.0**	**0.0**	**0.0**	**1.7**	**5**	**1.7**	**0.0**	**1**	**0.0%**	**20.0%**	**58.8%**
Psychological staff	Band 5			0.2				0.2	1	0.2					
	Band 6		0.3	0.1				0.4	3	0.4					
	Band 7			0.2				0.2	1	0.2		1			
	Total	**0.0**	**0.3**	**0.5**	**0.0**	**0.0**	**0.0**	**0.8**	**5**	**0.8**	**0.0**	**1**	**0.0%**	**20.0%**	**125.0%**
Social workers	Band 6					0.8		0.8	1						
	Band 7		4.2	0.9	2.4			7.5	2		1.6				
	Band 8 and above		0.3	0.3				0.6	1						
	Total	**0.0**	**4.5**	**1.2**	**2.4**	**0.8**	**0.0**	**8.9**	**4**	**0.0**	**1.6**	**0**	**15.3%**	**0.0%**	**0.0%**
Speech and language therapists	Band 7			0.3				0.3	1						
	Total	**0.0**	**0.0**	**0.3**	**0.0**	**0.0**	**0.0**	**0.3**	**1**	**0.0**	**0.0**	**0**	**0.0%**	**0.0%**	**0.0%**
Spiritual support staff	Band 5			0.1				0.1	1	0.1		1			
	Total	**0.0**	**0.0**	**0.1**	**0.0**	**0.0**	**0.0**	**0.1**	**1**	**0.1**	**0.0**	**1**	**0.0%**	**100.0%**	**1000.0%**
TOTALS		**1.0**	**13.1**	**10.7**	**3.6**	**2.3**	**0.0**	**30.7**	**30**	**4.8**	**1.6**	**4**	**5.0%**	**13.3%**	**13.1%**

* No pf SIP reported varied noticeably from return to return so the proportion of staff aged over 50 was calculated against SIP and FTE bases for comparison

Appendix 5: SE London NHS employed workforce, 2007 Source: Received from the NHS Information Centre for Health & Care

	All NHS Staff (minus LAS)	All Doctors[1]	All GPs (including GP retainers and GP registrars)[2]	All GPs (excluding GP retainers and GP registrars)[3]	GP Registrars	HCHS Doctors & Dentists[1]	Consultant (including Director of Public Health)	Doctors in training & equivalents[4]	Practice staff[5]	Practice Nurses	**All non-medical staff**	Qualified nursing, midwifery & health visiting staff	*of which* Registered Midwives	All qualified scientific, therap-eutic & technical staff	*of which* Qualified allied health prof-essionals	Target Group HCAs
	Head count	Head count	Head count	Head count	Head count	Head count	Head count	Head count	Head count	Head count	Head count	Head count	Head count	Head count	Head count	Head count
	44,847	**5,541**	**1,137**	**1,066**	**64**	**4,411**	**1,501**	**2,482**	**3,058**	686	**35,562**	**14,662**	**1,026**	**4,981**	**2,145**	**5,692**
Bromley Hospitals	2,869	353	-	-	-	353	125	180	-	-	2,516	1,100	100	291	134	432
Guys & St Thomas' Hospitals	9,448	1,278	-	-	-	1,278	422	810	-	-	8,170	3,238	278	1,443	462	704
King's College Hospital	6,413	1,093	-	-	-	1,093	354	641	-	-	5,320	2,433	231	920	305	486
Queen Elizabeth Hospital	2,338	303	-	-	-	303	96	194	-	-	2,035	968	151	225	102	332
Queen Mary's Sidcup	1,989	252	-	-	-	252	75	153	-	-	1,737	681	130	198	103	420
University Hospital Lewisham	2,792	342	-	-	-	342	115	213	-	-	2,450	1,144	136	260	110	378
Oxleas	2,218	128	-	-	-	128	58	45	-	-	2,090	759	-	305	108	551
S London & Maudsley	6,440	483	-	-	-	483	207	208	-	-	5,957	2,458	-	632	217	1,661
Bexley Care Trust	1,185	120	112	108	4	8	5	-	395	100	570	256	-	50	33	84
Bromley PCT	2,229	245	219	203	16	26	9	2	685	117	1,182	388	-	164	134	272
Greenwich Teaching PCT	1,505	179	150	140	9	30	7	1	393	116	817	313	-	149	125	48
Lambeth PCT	1,855	309	267	247	18	44	14	16	550	136	860	282	-	105	94	106
Lewisham PCT	1,781	239	194	181	11	47	5	17	497	115	930	363	-	102	95	112
Southwark PCT	1,785	217	195	187	6	24	9	2	538	102	928	279	-	137	123	106
LAS- all London	4,080	-	-	-	-	-	-	-	-	-	4,080	-	-	-	-	-

Notes:
1. Excludes Hospital Practitioners and Clinical Assistants, most of these also work as a GP.
2. All GPs include GP Providers, Other GPs, GP Registrars and GP Retainers
3. All GPs (excluding GP retainers and GP registrars) includes GP Providers and Other GPs
4. Doctors in training and equivalents includes House Officers & Foundation Year 1, Senior House Officers, Foundation Year 2, Registrars and equivalents who do not hold an educationally approved training post
5. Practice Staff includes Direct Patient Care staff, Admin & Clerical & Other
6. Qualified allied health professionals are qualified staff from chiropody, dietetics, occupational therapy, orthoptics/optics, physiotherapy, radiography, art/music/drama therapy and speech & language therapists.

Data as at 30 September 2007; from the NHS Information Centre for Health & Care

Appendix 6: SE London Social Care Staff- Local Authority Employed, 2007, by local authority

Source: Received from the NHS Information Centre for Health & Care

30th Sept 2007: Total Local Authority employed staff in SE London: head count

SSDS Code		England	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark
Section I	**STRATEGIC/ CENTRAL STAFF**							
1.1	Senior directing staff (Dir/Deputy Dir/Asst Dir)	700	-	-	-	15	-	-
1.2	Planning staff (advisers, planners, researchers)	2170	-	15	-	20	-	0
1.3	Training managers and officers	1640	-	-	-	-	-	-
1.4	Registration and inspection officers	70	0	0	0	0	0	0
1.5	Senior support staff (SO grade and above) not in 1.2-1.4	6120	25	-	45	120	25	75
1.6	Strategic/central support services staff	12170	40	5	30	135	5	10
	TOTAL	**22875**	**70**	**35**	**85**	**290**	**40**	**90**
Section II	**STAFF IN OPERATIONAL DIVISIONS/ NOT ESTABLISHMENT BASED**							
2.1	Assistant Directors, managers and principal officers not establishment based	1935	10	20	0	15	-	10
2.2	Area managers	1015	0	0	0	15	10	20
	Sub-total	2950	10	20	0	30	15	30
	Provision specifically for children's' services							
2.30	Team leaders/managers	3855	5	15	30	20	40	30
2.31	Assistant Team managers/senior social workers	4515	25	75	35	25	40	105
2.32	Care managers	225	0	0	0	10	0	0
2.33	Field social workers	12540	40	30	170	80	85	165
2.34	Social services officers/social work assistants	6165	25	30	25	15	30	65
2.35	Child Protection, Family Placement, Juvenile/Youth Justice workers	5245	-	25	35	-	10	30
2.36	Community workers	1845	-	0	0	0	0	0
2.37	Occupational therapists	210	0	0	0	0	0	0
2.38	OT assistants, equipment aids & other officers	1005	-	0	0	0	-	0
2.39	Technical officers	295	0	0	0	0	0	0
	Sub-total	35895	105	175	290	155	210	390
	Provision specifically for adult services							
2.40	Team leaders/managers	1670	-	-	5	10	15	-
2.41	Assistant Team managers/senior social workers	1470	-	0	-	10	10	10
2.42	Care managers	2120	-	0	45	-	0	20
2.43	Field social workers	4420	-	0	-	45	45	5
2.44	Social services officers/social work assistants	3830	0	10	25	40	-	5
2.45	Community workers	2185	0	0	0	70	0	0

2.46	Occupational therapists	1505	0	0	0	10	15	10
2.47	OT assistants, equipment aids & other officers	1355	0	0	0	0	10	5
2.48	Technical officers	315	0	0	-	0	0	-
	Sub-total	18870	5	15	85	185	95	60
	Hospitals/other health related settings							
	Field social workers providing health-related social work							
2.50	Team leaders/managers	365	-	-	0	-	-	0
2.51	Care managers	540	0	20	10	0	0	-
2.52	Social workers	2025	10	0	20	-	15	15
2.53	Social services officers/social work assistants	755	0	0	-	-	0	-
	All social workers employed by SSD in							
2.54	General Practice (e.g. Health Centres)	45	0	0	0	0	0	0
2.55	Other health settings (e.g. hospices)	30	0	0	0	-	0	0
	Sub-total	3760	10	25	35	15	20	15
	Specialist teams (not included above)							
	Alcohol, HIV/AIDS and drug centres							
2.60	Team leaders/managers	120	0	0	-	0	5	-
2.61	Asst team managers/senior social workers	100	0	0	-	0	0	-
2.62	Social workers	245	0	0	-	0	0	-
2.63	Care managers in alcohol, HIV/AIDS and drugs centres	110	0	0	-	0	-	0
2.64	Support workers	220	-	0	0	0	-	0
	Sub-total	795	-	0	10	0	10	-
	Other specialist teams (e.g. mental health, people with learning disabilities and/or physical disabilities)							
2.70	Team leaders/managers	1220	-	5	10	10	-	10
2.71	Assistant team managers & senior social workers	1360	-	15	-	10	10	30
2.72	Social workers	5310	20	-	15	55	40	65
2.73	Care managers in specialist teams for mental health etc.	1245	0	25	-	10	0	0
2.74	Support workers	4860	-	0	35	25	0	0
	Sub-total	13990	30	50	65	110	55	105
	Generic provision (not included in sections 2.2-2.7)							
2.80	Team leaders/managers	295	-	-	15	0	0	0
2.81	Assistant Team managers/senior social workers	240	15	20	-	0	-	-
2.82	Care managers	50	0	25	0	0	0	0

2.83	Field social workers	480	0	0	5	0	0	0
2.84	Social services officers/social work assistants	675	0	20	0	0	0	15
2.85	Community workers (inc. community development officers)	465	10	0	0	0	0	0
2.86	Occupational therapists	650	0	10	5	0	0	0
2.87	OT assistants, equipment aids & other officers	645	0	10	10	-5	0	
2.88	Technical officers	365	0	0	30	0	-5	0
2.89	Trainee social workers	370	-5	0	0	0	0	0
	Sub-total	4235	25	85	75	-5	10	15
	Other Staff:							
	Guardians ad litem							
2.90	Total staff employed within GAL	-5	0	0	0	0	0	0
	Transport							
2.91	Attendants, attendant drivers and escorts not establishment based	1160	0	35	0	15	0	0
2.92	Drivers not establishment based	825	0	0	0	0	0	0
2.93	Support services staff for lines 2.1-2.92	17560	50	110	80	-5	95	0
	Sub-total	19545	50	145	80	20	95	0
	Domiciliary service staff							
3.1	Home/domiciliary care/help organizers (inc. link service centre coordinators)	2075	-5	0	10	-5	10	0
3.2	Assistant and trainee home care/help organizers	1660	0	15	0	0	40	0
3.3	Home care staff/home helps (other than family aides in family centres)	36660	-5	185	30	-5	160	0
3.4	Wardens (where applicable)	830	0	0	0	0	0	0
3.5	Meals services staff where separately identifiable	550	0	0	0	0	0	0
3.6	Section 3: support services staff	2040	0	0	10	0	25	0
	Sub-total	43810	5	200	50	10	235	0
	TOTAL	**143860**	**255**	**710**	**690**	**520**	**750**	**620**
Section III	**DAY CARE PROVISION (including sheltered workshops where appropriate)**							
	Staff of day centres mainly for elderly people and elderly people with a mental infirmity							
4.1	Managers and officers in charge	315	-5	0	0	0	0	-5
4.2	Deputy officers in charge	230	-5	0	0	0	0	-5
4.3	Social work staff	30	0	0	0	0	0	0
4.4	Day centre officers	495	-5	0	0	0	0	20
4.5	Care staff	2310	5	0	0	0	-5	5

4.6	Other support services staff	1200	-	0	0	0	0	10
	Sub-total	4580	10	0	0	0	-	45
	Staff of day care centres mainly for people under 65 with physical disabilities							
5.1	Managers and officers in charge	130	0	0	0	0	0	-
5.2	Deputy officers in charge	95	0	0	-	-	0	-
5.3	Social work staff	30	0	0	-	0	0	0
5.4	Day centre officers	585	0	0	-	0	0	15
5.5	Care staff	690	0	0	0	-	0	-
5.6	Other support services staff	640	-	0	-	-	0	-
	Sub-total	2170	-	0	5	-	0	20
	Staff of day centres mainly for adults with mental health problems							
6.1	Managers and officers in charge	130	0	0	0	0	0	-
6.2	Deputy officers in charge	100	0	0	0	0	-	-
6.3	Social work staff	100	0	0	0	0	0	0
6.4	Day centre officers	730	0	0	0	0	0	-
6.5	Care staff	275	0	0	0	0	0	0
6.6	Other support services staff	355	0	0	0	0	0	-
	Sub-total	1690	0	0	0	0	-	5
	Staff of day centres mainly for adults with learning disabilities. (includes centres formerly referred to as adult training centres)							
7.1	Managers and officers in charge	605	0	-	0	-	10	-
7.2	Deputy officers in charge	700	0	-	0	0	0	-
7.3	Social work staff	155	0	0	0	0	0	0
7.4	Day centre officers	6245	0	20	45	0	45	40
7.5	Care staff	5430	0	5	0	0	-	0
7.6	Other support services staff	3045	0	10	-	-	-	-
	Sub-total	16180	0	40	50	-	60	50
	Staff in day care centres for mixed client groups (including sheltered workshops)							
8.1	Managers and officers in charge	110	0	0	0	0	15	0
8.2	Deputy officers in charge	130	0	0	0	0	0	0
8.3	Social work staff	10	0	0	0	0	0	0
8.4	Day centre officers	370	0	0	0	0	-	0

8.5	Care staff	555	0	0	0	0	0	0
8.6	Other support services staff	1025	0	0	0	0	10	0
	Sub-total	2200	0	0	0	0	25	0
	Family centres							
9.1	Officers in charge	285	-	0	0	0	0	0
9.2	Deputy officers in charge	300	0	0	0	0	0	0
9.3	Social workers based in family centres	185	-	0	0	0	0	0
9.4	Family centre workers, family aides & other care staff	3280	-	0	20	0	-	0
9.5	Other support services staff	835	20	0	-	0	0	0
	Sub-total	4885	25	0	25	0	-	0
	Staff in day nurseries							
10.1	Managers and officers in charge and nursery group leaders	95	0	-	0	0	0	0
10.2	Deputy officers in charge	115	0	-	0	0	0	0
10.3	Nursery officers, students and assistants	870	0	-	0	0	0	0
10.4	Other support services staff	325	0	-	0	0	0	0
	Sub-total	1400	0	10	0	0	0	0
	Staff in play groups							
11.1	Playgroup leaders and assistants	285	0	0	0	0	0	0
11.2	Other support services staff	35	0	0	0	0	0	0
	Sub-total	315	0	0	0	0	0	0
	Nursery centres where funded by social services							
12.1	Teachers (whether qualified or not)	20	0	0	0	0	0	0
12.2	Managers and officers in charge	10	0	0	0	0	0	0
12.3	Deputy officers in charge	-	0	0	0	0	0	0
12.4	Nursery officers, students and assistants	110	0	0	0	0	0	0
12.5	Other support services staff	25	0	0	0	0	0	0
	Sub-total	175	0	0	0	0	0	0
	Community centres							
13.1	Total staff employed by social services in community centres	55	0	0	0	0	0	0
	TOTAL	**33660**	**40**	**50**	**80**	**10**	**90**	**120**

Section IV	**CARE IN RESIDENTIAL ESTABLISHMENTS**							
	Staff of homes mainly for elderly people and elderly people with a mental infirmity							
14.1	Managers and officers in charge	750	0	5	0	0	0	0
14.2	Deputy officers in charge	990	0	0	0	0	0	0
14.3	Other supervisory staff (e.g. senior care officers)	2610	0	0	0	0	0	0
14.4	Care staff	17775	0	75	0	0	0	0
14.5	Other support services staff	7075	0	10	0	0	0	0
	Sub-total	29200	0	95	0	0	0	0
	Staff of homes mainly for people under 65 with physical disabilities							
15.1	Managers and officers in charge	30	0	0	0	0	0	0
15.2	Deputy officers in charge	30	0	0	0	0	0	0
15.3	Other supervisory staff (e.g. senior care officers)	150	0	0	0	0	0	0
15.4	Care staff	525	0	0	0	0	0	0
15.5	Other support services staff	135	0	0	0	0	0	0
	Sub-total	870	0	0	0	0	0	0
	Staff of homes and hostels mainly for adults with mental health problems							
16.1	Managers and officers in charge	80	0	0	0	0	-	0
16.2	Deputy officers in charge	90	0	0	0	0	0	0
16.3	Other supervisory staff (e.g. senior care officers)	190	0	0	0	0	20	0
16.4	Care staff	1050	0	0	0	0	0	0
16.5	Other support services staff	230	0	0	0	0	-	0
	Sub-total	1640	0	0	0	0	20	0
	Staff of homes and hostels mainly for adults with learning disabilities							
17.1	Managers and officers in charge	470	0	-	10	0	0	0
17.2	Deputy officers in charge	550	0	10	-	0	0	0
17.3	Other supervisory staff (e.g. senior care officers)	1420	0	0	0	0	0	0
17.4	Care staff	9735	0	45	100	0	0	0
17.5	Other support services staff	1290	0	-	-	0	0	0
	Sub-total	13465	0	55	115	0	0	0
	Staff of homes and hostels mainly for children with learning disabilities							
18.1	Managers and officers in charge	125	0	-	0	0	0	-
18.2	Deputy officers in charge	140	0	-	0	0	0	-
18.3	Other supervisory staff (e.g. senior care officers)	600	0	0	0	0	0	0

18.4	Care staff	1615	0	10	-	0	0	10
18.5	Other support services staff	370	0	-	0	0	0	-
	Sub-total	2855	0	15	-	0	0	15
	Staff of community homes for children looked after (including observation and assessment centres where mainly residential)							
19.1	Managers and officers in charge	475	0	0	-	0	0	0
19.2	Deputy officers in charge	635	0	0	0	0	0	0
19.3	Other supervisory staff (e.g. senior care officers)	1620	0	0	-	0	0	0
19.4	Child care staff	4885	0	0	5	0	0	0
19.5	Teaching staff	80	0	0	0	0	0	0
19.6	Other support services staff	1350	0	0	-	0	0	0
	Sub-total	9050	0	0	10	0	0	0
	TOTAL	**57085**	**0**	**165**	**125**	**0**	**20**	**15**
Section V	**SPECIALIST NEEDS ESTABLISHMENTS**							
	Staff in combined "specialist needs" establishments/ resource centres (which are designed to cater for some combination of residential/ significant levels of short stay/ day centre services)							
	(1) Mainly for elderly people							
20.1	Managers and officers in charge	95	0	0	0	0	0	0
20.2	Deputy officers in charge	170	0	0	0	0	0	0
20.3	Other supervisory staff (e.g. senior care officers)	555	0	0	0	0	0	0
20.4	Day centre officers	65	0	0	0	0	0	0
20.5	Care staff	2475	0	0	0	0	0	0
20.6	Teaching staff	10	0	0	0	0	0	0
20.7	Other support services staff	1005	0	0	0	0	0	0
	Sub-total	4375	0	0	0	0	0	0
	(2) Mainly for children [Includes observation assessment centres not included in item 19 above]							
21.1	Managers and officers in charge	80	0	0	0	0	0	0
22.2	Deputy officers in charge	95	0	0	0	0	0	0
22.3	Other supervisory staff (e.g. senior care officers)	320	0	0	0	0	0	0
22.4	Child care staff	940	0	0	-	0	0	0
22.5	Teaching staff	85	0	0	-	0	0	0
22.6	Other support services staff	405	0	0	0	0	0	0
	Sub-total	1930	0	0	-	0	0	0

	(3) Client groups other than elderly people or children							
22.1	Managers and officers in charge	25	0	0		0	0	0	0
22.2	Deputy officers in charge	20	0	0		0	0	0	0
22.3	Other supervisory staff (e.g. senior care officers)	20	0	0		0	0	0	0
22.4	Day centre officers	15	0	0		0	0	0	0
22.5	Care staff	260	0	0		0	0	0	0
22.6	Teaching staff	0	0	0		0	0	0	0
22.7	Other support services staff	100	0	0	-	-		0	0
	Sub-total	440	0	0	-	-		0	0
	TOTAL	**6745**	**0**	**0**	**-**	**-**		**0**	**0**

Section VI	**OTHER STAFF IN POST (not included above)**							
	All other staff	2630	10	0	15	0	0	180
	[LA to specify any significant numbers included here]							

TOTAL STAFF	**ENGLAND**	**BEXLEY**	**BROMLEY**	**GREENWICH**	**LAMBETH**	**LEWISHAM**	**SOUTHWARK**
Grand total all staff (sections I-VI)	**266850**	**370**	**960**	**1000**	**820**	**900**	**1030**

Appendix 7: SE London Social Care Staff- Private & third sector, as of April 2009- by borough
Source: Skills for Care NMDS-SC Online http://www.nmds-sc-online.org.uk/research/researchdocs.aspx?id=2

7.1 Lambeth

Employees		Total	Care home with nursing provision	Care home without nursing provision	Other adult residential	Adult day	Domiciliary care	Other adult domiciliary	Adult community care	Other service types
Private sector	Total Number of Staff Employed	1,764	650	296	41	..	678	*	0	45
	Permanent Staff	1,662	585	294	37	..	678	*	0	14
	Permanent Staff (%)	94.2%	90.0%	99.3%	90.2%	..	100.0%	*	0.0%	31.1%
	Temporary Staff	102	65	2	4	..	0	*	0	31
	Temporary Staff (%)	5.8%	10.0%	0.7%	9.8%	..	0.0%	*	0.0%	68.9%
	Vacancies	17	5	5	0	..	7	*	0	0
	Vacancy Rate	1.0%	0.8%	1.7%	0.0%	..	1.0%	*	0.0%	0.0%
	Employed Staff Started in the last 12 months	366	107	24	3	..	232	*	0	0
	Employed Staff Started in the last 12 months (%)	20.7%	16.5%	8.1%	7.3%	..	34.2%	*	0.0%	0.0%
	Employed Staff Left in last 12 months	363	75	19	0	..	253	*	0	16
	Turnover Rate	20.6%	11.5%	6.4%	0.0%	..	37.3%	*	0.0%	35.6%
Voluntary or 'third' sector	Total Number of Staff Employed	1,189	..	378	19	*	13	..	134	584
	Permanent Staff	1,178	..	378	19	*	13	..	130	582
	Permanent Staff (%)	99.1%	..	100.0%	100.0%	*	100.0%	..	97.0%	99.7%
	Temporary Staff	11	..	0	0	*	0	..	4	2
	Temporary Staff (%)	0.9%	..	0.0%	0.0%	*	0.0%	..	3.0%	0.3%
	Vacancies	48	..	18	3	*	0	..	5	22
	Vacancy Rate	3.9%	..	4.5%	13.6%	*	0.0%	..	3.6%	3.6%
	Employed Staff Started in the last 12 months	113	..	30	2	*	4	..	12	60
	Employed Staff Started in the last 12 months (%)	9.5%	..	7.9%	10.5%	*	30.8%	..	9.0%	10.3%
	Employed Staff Left in last 12 months	158	..	37	2	*	6	..	10	100
	Turnover Rate	13.3%	..	9.8%	10.5%	*	46.2%	..	7.5%	17.1%

7.2 Southwark

Employees		Total	Care home with nursing provision	Care home without nursing provision	Other adult residential	Adult day	Domiciliary care	Other adult domiciliary	Adult community care	Other service types
Private sector	Total Number of Staff Employed	688	292	50	4	..	301	*	..	12
	Permanent Staff	540	278	48	4	..	194	*	..	12
	Permanent Staff (%)	78.5%	95.2%	96.0%	100.0%	..	64.5%	*	..	100.0%
	Temporary Staff	148	14	2	0	..	107	*	..	0
	Temporary Staff (%)	21.5%	4.8%	4.0%	0.0%	..	35.5%	*	..	0.0%
	Vacancies	39	10	4	0	..	17	*	..	4
	Vacancy Rate	5.4%	3.3%	7.4%	0.0%	..	5.3%	*	..	25.0%
	Employed Staff Started in the last 12 months	37	20	3	0	..	1	*	..	0
	Employed Staff Started in the last 12 months (%)	5.4%	6.8%	6.0%	0.0%	..	0.3%	*	..	0.0%
	Employed Staff Left in last 12 months	117	57	7	18	..	31	*	..	0
	Turnover Rate	17.0%	19.5%	14.0%	450.0%	..	10.3%	*	..	0.0%
Voluntary or 'third' sector	Total Number of Staff Employed	1,501	92	648	130	53	353	*	107	78
	Permanent Staff	1,442	86	637	128	53	353	*	104	71
	Permanent Staff (%)	96.1%	93.5%	98.3%	98.5%	100.0%	100.0%	*	97.2%	91.0%
	Temporary Staff	59	6	11	2	0	0	*	3	7
	Temporary Staff (%)	3.9%	6.5%	1.7%	1.5%	0.0%	0.0%	*	2.8%	9.0%
	Vacancies	84	1	38	19	1	0	*	15	10
	Vacancy Rate	5.3%	1.1%	5.5%	12.8%	1.9%	0.0%	*	12.3%	11.4%
	Employed Staff Started in the last 12 months	137	3	88	8	2	12	*	3	6
	Employed Staff Started in the last 12 months (%)	9.1%	3.3%	13.6%	6.2%	3.8%	3.4%	*	2.8%	7.7%
	Employed Staff Left in last 12 months	115	8	41	12	1	30	*	6	13
	Turnover Rate	7.7%	8.7%	6.3%	9.2%	1.9%	8.5%	*	5.6%	16.7%
Other	Total Number of Staff Employed	237	..	..	..	156	81	..	..	..
	Permanent Staff	237	..	..	..	156	81	..	..	..
	Permanent Staff (%)	100.0%	..	..	..	100.0%	100.0%	..	..	..

Temporary Staff	0	..	..	..	0	0	..	..	..
Temporary Staff (%)	0.0%	..	..	..	0.0%	0.0%	..	..	..
Vacancies	0	..	..	..	0	0	..	..	..
Vacancy Rate	0.0%	..	..	..	0.0%	0.0%	..	..	..
Employed Staff Started in the last 12 months	7	..	..	..	0	7	..	..	..
Employed Staff Started in the last 12 months (%)	3.0%	..	..	..	0.0%	8.6%	..	..	..
Employed Staff Left in last 12 months	87	..	..	..	85	2	..	..	..
Turnover Rate	36.7%	..	..	..	54.5%	2.5%	..	..	..

7.3 Lewisham

Employees		Total	Care home with nursing provision	Care home without nursing provision	Other adult residential	Adult day	Domiciliary care	Other adult domiciliary	Adult community care	Other service types
Private sector	Total Number of Staff Employed	1,914	628	339	*	..	870	..	..	68
	Permanent Staff	1,754	593	332	*	..	803	..	..	17
	Permanent Staff (%)	91.6%	94.4%	97.9%	*	..	92.3%	..	..	25.0%
	Temporary Staff	160	35	7	*	..	67	..	..	51
	Temporary Staff (%)	8.4%	5.6%	2.1%	*	..	7.7%	..	..	75.0%
	Vacancies	27	2	5	*	..	20	..	..	0
	Vacancy Rate	1.4%	0.3%	1.5%	*	..	2.2%	..	..	0.0%
	Employed Staff Started in the last 12 months	114	53	24	*	..	37	..	..	0
	Employed Staff Started in the last 12 months (%)	6.0%	8.4%	7.1%	*	..	4.3%	..	..	0.0%
	Employed Staff Left in last 12 months	324	74	21	*	..	228	..	..	1
	Turnover Rate	16.9%	11.8%	6.2%	*	..	26.2%	..	..	1.5%
Voluntary or 'third' sector	Total Number of Staff Employed	680	111	163	*	*	122	*	130	23
	Permanent Staff	679	111	162	*	*	122	*	130	23
	Permanent Staff (%)	99.9%	100.0%	99.4%	*	*	100.0%	*	100.0%	100.0%
	Temporary Staff	1	0	1	*	*	0	*	0	0
	Temporary Staff (%)	0.1%	0.0%	0.6%	*	*	0.0%	*	0.0%	0.0%
	Vacancies	50	4	9	*	*	4	*	6	0
	Vacancy Rate	6.8%	3.5%	5.2%	*	*	3.2%	*	4.4%	0.0%
	Employed Staff Started in the last 12 months	79	9	24	*	*	4	*	9	1
	Employed Staff Started in the last 12 months (%)	11.6%	8.1%	14.7%	*	*	3.3%	*	6.9%	4.3%
	Employed Staff Left in last 12 months	85	4	21	*	*	11	*	12	1
	Turnover Rate	12.5%	3.6%	12.9%	*	*	9.0%	*	9.2%	4.3%
Other	Total Number of Staff Employed	20	..	20	..	..	..	..	..	..
	Permanent Staff	20	..	20	..	..	..	..	..	..
	Permanent Staff (%)	100.0%	..	100.0%	..	..	..	..	..	..

	Temporary Staff	0	..	0	..	..	..	..	..	..
	Temporary Staff (%)	0.0%	..	0.0%	..	..	..	..	..	..
	Vacancies	0	..	0	..	..	..	..	..	..
	Vacancy Rate	0.0%	..	0.0%	..	..	..	..	..	..
	Employed Staff Started in the last 12 months	3	..	3	..	..	..	..	..	..
	Employed Staff Started in the last 12 months (%)	15.0%	..	15.0%	..	..	..	..	..	..
	Employed Staff Left in last 12 months	3	..	3	..	..	..	..	..	..
	Turnover Rate	15.0%	..	15.0%	..	..	..	..	..	..

7.4 Bromley

Employees		Total	Care home with nursing provision	Care home without nursing provision	Other adult residential	Adult day	Domiciliary care	Adult community care	Other service types
Private sector	Total Number of Staff Employed	2,094	489	737	30	..	707	..	*
	Permanent Staff	1,900	482	732	19	..	536	..	*
	Permanent Staff (%)	90.7%	98.6%	99.3%	63.3%	..	75.8%	..	*
	Temporary Staff	194	7	5	11	..	171	..	*
	Temporary Staff (%)	9.3%	1.4%	0.7%	36.7%	..	24.2%	..	*
	Vacancies	52	5	35	1	..	11	..	*
	Vacancy Rate	2.4%	1.0%	4.5%	3.2%	..	1.5%	..	*
	Employed Staff Started in the last 12 months	145	14	117	1	..	12	..	*
	Employed Staff Started in the last 12 months (%)	6.9%	2.9%	15.9%	3.3%	..	1.7%	..	*
	Employed Staff Left in last 12 months	233	50	105	2	..	75	..	*
	Turnover Rate	11.1%	10.2%	14.2%	6.7%	..	10.6%	..	*
Voluntary or 'third' sector	Total Number of Staff Employed	679	170	364	12	*	100	26	*
	Permanent Staff	668	160	364	11	*	100	26	*
	Permanent Staff (%)	98.4%	94.1%	100.0%	91.7%	*	100.0%	100.0%	*
	Temporary Staff	11	10	0	1	*	0	0	*
	Temporary Staff (%)	1.6%	5.9%	0.0%	8.3%	*	0.0%	0.0%	*
	Vacancies	25	2	15	6	*	0	2	*
	Vacancy Rate	3.6%	1.2%	4.0%	33.3%	*	0.0%	7.1%	*
	Employed Staff Started in the last 12 months	49	13	27	4	*	0	5	*
	Employed Staff Started in the last 12 months (%)	7.2%	7.6%	7.4%	33.3%	*	0.0%	19.2%	*
	Employed Staff Left in last 12 months	58	22	22	3	*	11	0	*
	Turnover Rate	8.5%	12.9%	6.0%	25.0%	*	11.0%	0.0%	*

7.5 Bexley

Employees		Total	Care home with nursing provision	Care home without nursing provision	Other adult residential	Adult day	Domiciliary care	Other adult domiciliary	Adult community care	Other service types
Private sector	Total Number of Staff Employed	847	*	210	*	27	386	*	18	35
	Permanent Staff	834	*	208	*	27	386	*	18	34
	Permanent Staff (%)	98.5%	*	99.0%	*	100.0%	100.0%	*	100.0%	97.1%
	Temporary Staff	13	*	2	*	0	0	*	0	1
	Temporary Staff (%)	1.5%	*	1.0%	*	0.0%	0.0%	*	0.0%	2.9%
	Vacancies	24	*	7	*	0	16	*	0	0
	Vacancy Rate	2.8%	*	3.2%	*	0.0%	4.0%	*	0.0%	0.0%
	Employed Staff Started in the last 12 months	140	*	44	*	0	78	*	0	6
	Employed Staff Started in the last 12 months (%)	16.5%	*	21.0%	*	0.0%	20.2%	*	0.0%	17.1%
	Employed Staff Left in last 12 months	140	*	43	*	5	84	*	0	1
	Turnover Rate	16.5%	*	20.5%	*	18.5%	21.8%	*	0.0%	2.9%
Voluntary or 'third' sector	Total Number of Staff Employed	1,114	..	586	..	13	452	..	42	21
	Permanent Staff	1,091	..	586	..	12	430	..	42	21
	Permanent Staff (%)	97.9%	..	100.0%	..	92.3%	95.1%	..	100.0%	100.0%
	Temporary Staff	23	..	0	..	1	22	..	0	0
	Temporary Staff (%)	2.1%	..	0.0%	..	7.7%	4.9%	..	0.0%	0.0%
	Vacancies	13	..	5	..	1	5	..	1	1
	Vacancy Rate	1.2%	..	0.8%	..	7.1%	1.1%	..	2.3%	4.5%
	Employed Staff Started in the last 12 months	15	..	5	..	2	5	..	1	2
	Employed Staff Started in the last 12 months (%)	1.3%	..	0.9%	..	15.4%	1.1%	..	2.4%	9.5%
	Employed Staff Left in last 12 months	21	..	11	..	3	3	..	1	3
	Turnover Rate	1.9%	..	1.9%	..	23.1%	0.7%	..	2.4%	14.3%

7.5 Greenwich

Employees		Total	Care home with nursing provision	Care home without nursing provision	Other adult residential	Adult day	Domiciliary care	Adult community care	Other service types
Private sector	Total Number of Staff Employed	1,299	782	194	*	..	285	..	27
	Permanent Staff	1,243	750	191	*	..	265	..	27
	Permanent Staff (%)	95.7%	95.9%	98.5%	*	..	93.0%	..	100.0%
	Temporary Staff	56	32	3	*	..	20	..	0
	Temporary Staff (%)	4.3%	4.1%	1.5%	*	..	7.0%	..	0.0%
	Vacancies	27	4	17	*	..	6	..	0
	Vacancy Rate	2.0%	0.5%	8.1%	*	..	2.1%	..	0.0%
	Employed Staff Started in the last 12 months	129	61	34	*	..	34	..	0
	Employed Staff Started in the last 12 months (%)	9.9%	7.8%	17.5%	*	..	11.9%	..	0.0%
	Employed Staff Left in last 12 months	178	107	30	*	..	30	..	11
	Turnover Rate	13.7%	13.7%	15.5%	*	..	10.5%	..	40.7%
Voluntary or 'third' sector	Total Number of Staff Employed	1,396	421	292	*	18	413	104	18
	Permanent Staff	1,238	337	287	*	18	347	101	18
	Permanent Staff (%)	88.7%	80.0%	98.3%	*	100.0%	84.0%	97.1%	100.0%
	Temporary Staff	158	84	5	*	0	66	3	0
	Temporary Staff (%)	11.3%	20.0%	1.7%	*	0.0%	16.0%	2.9%	0.0%
	Vacancies	59	14	5	*	6	20	9	0
	Vacancy Rate	4.1%	3.2%	1.7%	*	25.0%	4.6%	8.0%	0.0%
	Employed Staff Started in the last 12 months	82	73	3	*	0	0	6	0
	Employed Staff Started in the last 12 months (%)	5.9%	17.3%	1.0%	*	0.0%	0.0%	5.8%	0.0%
	Employed Staff Left in last 12 months	109	40	6	*	1	50	5	1
	Turnover Rate	7.8%	9.5%	2.1%	*	5.6%	12.1%	4.8%	5.6%

Appendix 8: Findings from MCDC Programme Phase 1 Scoping- education & training

The Phase I investigation highlighted various issues and barriers to the education and development for professionals, which have been detailed and categorised as follows:

Recognition of palliative care patients and the dying phase / Identification of their needs

- Many healthcare professionals do not recognise that a patient is near the end of life therefore care options are only discussed when a patient becomes acutely unwell.
- There is a lack of recognition by healthcare professionals in the community regarding when active treatment is futile and therefore admission to hospital may be of little benefit
- Sometimes GPs lack knowledge and confidence in end of life care
- Staff are not always able to recognise when a patient is entering the dying phase
- Recognition of the dying phase in patients with a non cancer diagnosis is often more difficult due to varying disease trajectories
- Patients are not being clearly identified as being palliative care patients and being actively managed through this phase. Medical teams and consultants have difficulty in moving their patients from curative to palliative care and consequently patients are being actively treated during the terminal phase.
- Non cancer patients have a different disease trajectory and it can be difficult to predict when they are entering the dying phase, this can mean that this group of patients are not given an opportunity to discuss their preferences for the end of life.
- There is a lack of education by hospital staff of patient and carers, especially in relation to information on the dying process and how this can be recognised.
- It can be difficult for the medical team to give a prognosis for heart failure and respiratory patients. This can mean that recognition of when the patient is dying can be problematic and difficult.
- Further training of how to identify when the patient has entered the end of life phase and the basic principles of palliative care.
- Training should be provided for social workers around the recognition of palliative care needs
- For patients who have end stage heart failure, who might be on wards other than CCU, their palliative care needs might not be identified which means their eligibility for continuing care funding is not recognised.

Communication Skills / Breaking Bad News

- Many nurses interviewed acknowledged that breaking bad news is a really difficult job and due to time constraints, they try to avoid it. They feel it's easier to discuss such issues with patients' families but not with patients themselves –they are "fearful of upsetting the patient". Others felt that they would appreciate support and guidance for example from the Palliative Care Team with "approaching difficult conversations"
- There is a tendency to leave death and dying discussions with patients and families to the Palliative Care Team. Ward nurses should be better such discussions with their patients.
- Some doctors break bad news to patients without ensuring the ward nurse and/or a family member is with them. Often nurses find patients crying without prior knowledge that the doctor had been to see them. Basic communication skills need to improve
- Some cardiac and respiratory staff said they do not like talking about end of life issues with patients as they don't want to take hope away from them even though they recognise the patient's condition is not curable.

- Discussions around resuscitation status are very variable. This if often prompted by the Palliative Care Team and/or ward sister. Staff have mixed opinions about how this should be handled. Some felt that doctors can get confused about who they should discuss this with, for example, they go to the relatives when they should be discussing it with the patient. Others felt the patient and family shouldn't been consulted as the outcome will be the same regardless of whether the patient is resuscitated or not.
- Health and social care professionals have difficulty discussing death and dying with patients and carers and this can mean that conversations are avoided or are not done effectively
- It is difficult to know when to have discussion around preferred place of care
- In some cases, conversations with patients and their families around preferred place of care, diagnosis and prognosis and options are not taking place.
- The extent to which death and dying is discussed with the patient varies, this reflects the level of understanding and skills ward nurses have particularly for patients with only days to live. It can all too often be assumed that the palliative care team will deal with the sensitive issues and free the nurses to undertake other tasks.
- Deciding when to have difficult conversations with patients and their carers can be difficult. This is due to some patients having lengthy disease journeys over many years and periods of being well after periods of being unwell.
- Staff have limited experience in initiating conversations with patients and their carers about the possibility that they may be near the end of life.
- GPs are sometimes very reluctant to initiate these difficult conversations with patients and their carers.

<u>Patients with LTC needing palliative care</u>

- There is very little is known amongst general healthcare professionals about palliative care need for patients with dementia.
- Caring for patients with dementia prove challenging because they are not always able to communicate their wishes or needs.
- MCNS does not always know the patient pathway for conditions other than cancer.
- GPs felt that the all health care professionals need to better understand the needs of non cancer patients in respect of the palliative care needs, involving palliative care team throughout.

<u>Palliative Care Knowledge and Skills</u>

- It is very difficult to know when a patient's needs are predominately palliative care, particularly for patients with heart failure.
- Various professionals had different levels of understanding of palliative care. One ward sister stated that a patient is not palliative until they have been seen by the Palliative Care Team. Other nurses felt as junior members of staff they wait to be told a patient is palliative rather than identifying this themselves.
- Staff have a poor understanding of patients' and families' spiritual needs both before and after death. This section on the LCP documentation is hardly ever completed.
- There is limited recognition by all healthcare staff, within all specialities, as to when to stop active treatment and begin to provide good quality palliative care.
- There is a lack of education in palliative care within the hospital for all healthcare professionals and support staff.

- There is minimal training for GPs providing OOH care in palliative care to prevent palliative care patients attending the A&E department
- There are no formal training programmes for front line staff with regards to discussing with patients wishes with them e.g. preferred place of care.
- There are limited skills of staff in nursing homes to care for palliative care patients.
- The hospital patient transport service is unable to take patients requiring more than 4 litres of oxygen.
- The hospital patient transport service is unable to take patients with a syringe driver.
- Hospital patient transport service crews do not receive any training in palliative care.
- Medical staff have a limited knowledge and understanding of palliative care drugs
- Ward nurse do not have adequate skills and training in planning discharges.
- The level of training and skills of paediatric service providers is of a higher standard to adult services. Many of the home care packages provided for children are from specialised services which provide training for staff. Adult services tend to be generic workers that provided care for all disease types and all ages where carers do not receive adequate training or support.
- Ambulance staff do not receive training on palliative care and they are not skilled to deal with dying patients; they are not used to seeing someone die “naturally”
- Education of ambulance crew on end of life care is a low priority
- There are minimal training and education programmes for DNs. For example, DNs receive IV training but not in the management of Hickman lines. DNs used to have training from cancer link – the courses are difficult to access due to resource constraints which could be addressed by better use of lunchtime training sessions.
- District nurses highlighted that the change in provision of training and education from the hospices to universities has resulted in training that is too academic, inflexible and reduces the opportunity for DNs to learn from role models and experienced practitioners in the end of life field.
- Concern was expressed with over sedation of patients at the end of their lives.
- GPs out of hours have a lack of knowledge and understanding around palliative care medication and lack confidence when prescribing syringe drivers.
- New nurses coming through the system are less inquisitive and there appears to be a large theory-practice gap, they appear not to have leadership or role models in the clinical areas advocating a holistic approach to care.
- The team used to provide the palliative care training to health care professionals including one to one sessions with district nurses. Education is now provided by both Kings College University and the hospice which is good but the local role modelling and education has been lost.
- There are variable degrees of good quality basic nursing skills in nurses and health care assistances within the ward areas.
- The end of life needs of end stage heart failure patients on wards are not always understood and patients are being denied access to the expertise on the coronary care unit (CCU) and necessary discussion around preferred place of care.
- Social carers are unqualified.
- Personal care provided by domiciliary care agencies was described as “awful”.
- Care agency staff are task orientated and do not address emotional or psychological issues.

- Heart failure patients deteriorate slowly and they adjust to this, not necessarily conveying a true picture to their GP. An understanding of this needs to be incorporated into GP training to raise awareness of the needs of heart failure patients.
- Social workers have limited understanding of palliative care and the different services available.
- The discharge coordinator services are “inadequately” resourced with poorly trained staff
- There should be more training for all staff on palliative care and end of life care issues
- Domiciliary Care staff do not receive adequate training.
- There needs to be consistent training for all social carers.
- There needs to be an increase in the provision of training by specialist palliative care for domiciliary carers.
- There is no mandatory standard uniform training across the borough for district nurses. This should be a rolling programme and include symptom control but also the non physical issues like finances.
- Nursing home staff need more training and education to improve their skills.
- District nurses are now caring for more non cancer end of life patients and they are going to need increased education to recognise when non cancer patients are entering the terminal stage. There needs to be preparation of staff because this is going to have a large impact on healthcare provision.
- There is limited number of senior nurses who are experienced in providing palliative care and end of life care. This means junior nurses are unable to accompany a skilled nurse in palliative care and learn from their experience. This is because of larger caseloads and DNs not having the skills to care for palliative care patient.
- Concern was expressed with over sedation of patients at the end of their life.
- Staff training on caring for patients from black and ethnic minorities is only available once a year so if it is missed the social worker has to wait until the following year for training.
- There is an increasing level of expectation placed on domiciliary care staff without additional resources or training.
- Some District Nurses are reluctant to get involved in providing care for palliative care patients due to lack of confidence.
- Some DNs may not have had experience asking for palliative care patients.
- Staff from some religions and cultures find it very difficult to care for palliative care patients.
- There needs to be improved training for staff at care homes in managing crisis;
- Care agencies do not provide training in palliative care for their staff so these impacts on the quality of care provided.
- There is a gap in education and training for district nurses. Due to time restrictions district nurses are unable to be released and therefore are unable to attend updates and training.
- There should be more specialist input for non-cancer patients and improved communication between palliative care and other specialities. It was recommended there should be greater awareness, education and opportunity to gain experience for GPs which would serve to build up confidence in managing and responding to the needs of the patients and the reassurance of being able to access specialist input
- Nurses at care homes often lack the skill and experience in appropriate management for end of life patients.
- Home care staff are not trained in palliative care

- Attendees at the focus groups said that training was available through their local hospices but some found it difficult to access training at hospices if they were not part of the GSF training programme.
- Palliative care training is required for non-nursing staff but it is difficult to access.
- As care homes do not use syringe drivers regularly, refresher courses are needed to maintain their skills.
- Some doctors do not have up to date knowledge of palliative care and will discuss patient's needs with the Marie Curie nurse.
- Staff working within mental health services are unable to recognise when a patient has entered the end of life stage. The signs are often subtle and they do not have the skills or expertise to recognise them.
- Staff working within mental health services have limited skills and knowledge of general palliative care and are not aware of the physiological changes that occur when someone is dying.
- There is a perception that patients may not require pain relief if they have a mental health condition, for example dementia.
- Staff do not have the skills to set up and monitor a syringe driver.

Utilising appropriate specialist resources i.e. Palliative Care Team

- Many patients are not referred early enough to the Palliative Care Team. Often they are referred when they are very near the end of their life
- For patients with particular diseases such as heart failure, it is difficult to know when they are near the end of their life however, it is felt the palliative care team should be involved earlier.

Preferred Priorities of Care (PPC)

- Doctors and ward nurses do not discuss preferred place of care and general issues about dying frequently enough.
- Whether a patient is asked about preferred place of care is variable and if they are, it is asked very near the end of life.
- There is uncertainty amongst the healthcare professionals as to the right time to discuss the patient's preferred place of care.
- A patient's preferred place of care, although discussed, might not always be taken into consideration. For example, one patient had initially expressed a wish to go home although his wife felt she would not be able to cope. At the point his condition improved, discharge to a nursing home was the only option.

Utilisation of LCP

- There is limited use of the LCP on the haematology ward by the nursing and medical team.

Care Homes

- Some care homes do not have the right level of staff to recognise when a patient/resident is deteriorating. This results in avoidable admissions for example dehydration.
- The LCP is not needed regularly in care homes; therefore it is difficult for staff to retain knowledge on the use of it.

Attendance and access to Education and Training sessions/events

- Palliative care training sessions are poorly attended. It is also felt to be given a low priority
- Attendance at training on the use of the LCP is poor
- The palliative care team provides the introduction of and training on palliative care, though attendance at training sessions is low.
- Training is available through the local hospices but some found it difficult to access training if they are not part of the GSF training programme.
- For social workers accessing training can be difficult because of high work load and pressure to met targets.

Support/ Advice / Information for families and carers

- It is felt that doctors and sometimes nurses are not good at checking if the patient and family have understood everything.

Continuing Health Care Funding

- There is a lack of understanding by nurses regarding continuing care funding.
- Palliative care patients need to be identified earlier to ensure continuing care funding can be organised in a timely way
- There is a lack of understanding by ward nurses regarding continuing care funding
- The continuing forms are long and complex and require a number of staff to complete them. This often portrays a disjointed picture of the patient's needs.
- There is minimal understanding of the process, criteria and responsibilities of staff completing the forms.
- There is a lack of clarity around the category changes for applying for continuing care funding which can delay discharge.
- The complex needs of palliative care patients in relation to continuing care can often be misunderstood: patient's with a poor prognosis who might not have specialist palliative care needs but still require nursing input can be identified as category 2 irrespective of MDT opinion.

Below we present the findings and topics for further training for two professional groups that are critical in delivering care in the community (GPs and DN's) and the results of a survey that we undertook with care home managers about palliative care training within care homes.

General Practitioners (GPs)

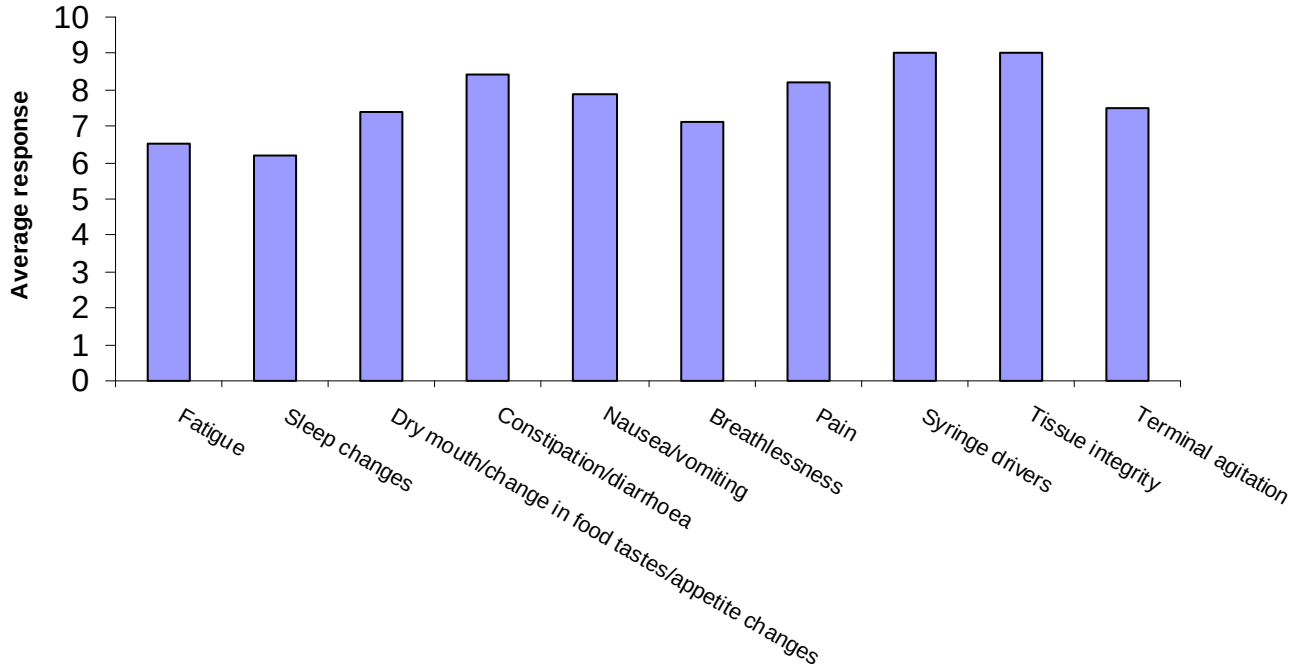
106 GPs responded to questions related to their training needs in palliative care including specific topics that they would like refreshing or further training on. Answering the question if they would like further training in palliative care, 84% of the respondents answered that they will benefit from further training in palliative care. The topics that were highlighted for further training include:

- Breaking bad news
- Addressing end of life issues with patients and family
- Dealing with psychological issues
- Addressing social needs
- Spiritual care
- Cultural aspects in palliative care and issues related to ethnic groups

- Dealing with palliative care emergencies
- Symptom management: Pain management; dealing with patients symptoms other than pain: nausea; itching
- Medicines management: - new approaches and update on current drug management; Update on syringe drivers
- Review of current clinical care and modern advances; Keeping abreast of developments
- Advanced directives
- Advice on Benefits
- Update on communication
- How to help young children in bereavement situation

District nurses (DNs)

41 DNs responded to the questionnaire. The respondents scored themselves of their ability in managing a list of physical symptoms [score: zero (not effective) to ten (very effective)]. The respondents scored around average for managing physical symptoms such as fatigue; sleep changes; and breathlessness.



Further questions in understanding their training needs in addressing psychological, social and spiritual issues showed that approximately half of them would have benefited from further training on dealing with psychological, social and spiritual issues.

Issue	Response - capability	Response - training
Effectiveness in addressing patient and family concerns regarding psychological issues	29% felt they were average in this area	44% felt they would benefit from training in this area
Effectiveness in addressing patient and family concerns regarding social/relationship conflict issues	29% felt they were average in this area	54% felt they would benefit from training in this area
Effectiveness in addressing patient and family concerns regarding spiritual issues	37% felt they were average in this area	56% felt they would benefit from training in this area

63% of the respondents answered that they will benefit from training on cultural aspects in palliative care and issues related to ethnic groups.

The following were highlighted as areas where additional training would be beneficial:

- Symptom control and updates on managing nausea, fatigue, vomiting, breathlessness, pain, constipation; spinal cord compression, titration of analgesia; agitation; bladder retention; Sleep disturbance; Dry mouth/appetite; problems with profuse bleeding; anxiety/agitation
- Blood result interpretation
- Update on new medications and drug available
- Psychological support
- Counselling; Dealing with family carers not accepting diagnosis; how to deal with relatives; answering difficult questions; how to advice patients;
- Managing: All types of cancer including symptom control after Chemotherapy; heart disease; end stage heart failure; Lymphodoema; MND, HIV, CCF; COPD; Parkinson's, MS, Renal failure
- Respiratory training

Care Homes

31 care home managers responded in the survey. 97% of the respondents felt that their staff would benefit from further training in palliative care.

Question -Have any staff in the care home received training in palliative care and end of life care?

Yes	No
18 (58%)	13 (42%)

Question- Do you feel that staff would benefit from more training in palliative care?

Yes	No
30 (97%)	1 (3%)

The following were highlighted as areas where additional training would be beneficial

- Symptom control, keeping a person comfortable & pain free; recognising changes in patient;
- Use of syringe driver for pain control
- Physical disabilities i.e. M.S, muscular dystrophy, stroke and diabetes
- End of life for frail elderly people and mental health.
- Cancer, Parkinson, Dementia, CCF and COPD, renal failure; Alzheimer's disease and Dementia; liver disease
- How to deal with depression, Parkinson's disease and confusion
- Basic physiology for metastatic disease
- Communicate bad news and communication with relatives; listening skills, working with families; counselling and bereavement
- How to approach relatives and patients regarding the advanced directive
- Ethics surrounding "not for resuscitation" instructions
- How staff could implement GSF and how to explain GSF to family

Phase II – Development of new models

Phase II of the project has commenced with the formation of five work streams including the establishment of a working group to explore how education and training for health, social care and carers can be improved.

The purpose of the education and training work stream is to address and design a range of solutions to enhance training provision and improve access to current training to professionals involved in the care of palliative care patients.

The following groups will benefit from training in palliative care:

- Social care workers; staff from agencies contracted by social and health care; ambulance crew; care/nursing home staff. These groups of professionals although are involved in the care of palliative care patients have received minimal or no training in palliative care.
- Health care professionals as GPs, DNs, hospital nursing staff that have already received some form of training in palliative care but there is need for further refreshing courses in a variety of topics.
- Hospital doctors: there is need in accepting that palliative care is an option, explore ways in determining when curative treatment is not an option, and acknowledging that patients may not wish to undertake further treatment
- Communication skills, breaking bad news and discussing end of life were also highlighted as one area for further training for professionals that have such responsibilities.
- Information on training and access to training including release of staff to undertake training.

The Phase I investigation highlighted various areas for improvements that are categorised below.

<u>Recognition of palliative care patients and the dying phase / Identification of their needs</u>

- To develop nursing home staff in recognising when a patient is entering the terminal phase and how to manage them in their current environment.
- All palliative care patients need to be identified early to complete the discharge process in good time.
- Further training of how to identify when the patient has entered the end of life phase and the basic principles of palliative care.

<u>Palliative Care Knowledge and Skills</u>

- It was suggested that there needs to be a formalised education programme for all health care professionals. This should include communication skills especially when discussing diagnosis, prognosis and preferred place of care.
- Health care professionals within the hospital need further training in palliative care.
- There needs to be more training and education for all professionals around palliative care and end of life care
- There should be collaborative training amongst professionals
- Further training of how to identify when the patient has entered the end of life phase and the basic principles of palliative care.
- There needs to be consistent training for all social carers.
- There needs to be an increase in the provision of training by specialist palliative care for domiciliary carers
- There needs to be consistent training for all social carers.
- There needs to be an increase in the provision of training by specialist palliative care for domiciliary carers.
- District nurses to have regular updates and training from specialist palliative care providers.
- District nurses should have more autonomy in organising and caring for patients and their carers

- Providing further training in managing end of life patients, strengthening guidelines and tightening governance arrangements
- Improving GPs confidence in caring for specialist palliative care patients.
- GPs need to know what to prescribe for symptom control – there needs to be open evenings for GPs to educate and raise awareness.
- More education on palliative care for DN's, nurses in care homes in particular:
    - syringe driver training
    - end of life (ambulances are often called as staff in care homes do not recognise the dying phase).
- GPs should have a better understanding of specialist palliative care.
- There needs to be education for patients, carers and professionals about the role of the hospice and the benefits and when they should be referred.
- Ongoing educational support for community staff with more collaborative training.
- There needs to be better care provided by agencies that are more tailored to caring for palliative care patients
- Education for the out of hours GP service on palliative care prescribing.
- There should be more care staff and staff trained in palliative care to provide packages of care to palliative care patients in the community
- There should be further education for district nurses and GPs on palliative care and not just for patients with cancer and when to refer patients to the specialist palliative care teams
- More education and training for all health and social professionals on caring for patients at the end of life
- Care agency staff should be provided with appropriate training to care for palliative care patients
- Basic training and education on palliative care and end of life care should be provided for all ambulance crews
- ECPs' skills and knowledge should be developed further so they can care for palliative care and end of life care patients
- There is a need to increase awareness of palliative care issues amongst staff and patients
- There is a need to increase training for district nurses and inexperienced nurses in palliative care. There is a need for students to gain further hands on experience in end of life care.
- It was suggested that the London ambulance service (LAS) need further training in diffusing a crisis situation in the home when a patients starts the dying process so that they do not automatically transfer the patient to the hospital. They need training in administering palliative care medication to settle the patient.
- Training should be provided for ambulance crew on palliative care
- There should be an increase in education in palliative care for all members of the hospital team caring for palliative care patients.
- There needs to be an increase in the provision of training by specialist palliative care for domiciliary carers.
- For Social services: There should be end of life care training available for all front line staff.
- There needs to be consistent training for all social carers.
- Inappropriate emergency admissions of end of life patients to hospital may be reduced with:

- training and advice on supporting patients and carers at point they would otherwise dial 999 - fear / panic or if they can't access support and care from appropriate services in the community; and
- It was felt that both district nurses and SELDOC may require further training to comply with gold standards framework.
- GPs felt that care homes staff are sometimes scared of being accused of negligence when a patient deteriorates. There is a need for further training, awareness which would also safeguard care home staff.
- DNs would like more training in palliative care particularly regarding new medications.

Care Homes

- It was suggested that there should be better education for care home staff around end of life care

Patients with LTC needing palliative care

- further development and training for care home staff in particular in caring for patients with dementia;
- The palliative care needs of end stage heart failure patients needs to be incorporated into the training on the needs of end stage palliative care patients.
- It was suggested that patients, especially those with a non cancer diagnosis, should be able to discuss death, dying and their disease trajectory as early on in the disease as possible. It was thought that this could start within the out patient clinics; this would allow patients and relatives to be prepared for those conversations later on.
- Meeting the skill and knowledge requirements of DNs in caring for renal, respiratory or heart failure patients could perhaps be a training role for community matrons.
- Suggested improvements for patients with non-cancer included:
    - better interaction with social care in planning and monitoring;
    - improved awareness and education for health care professionals

Communication Skills / Breaking Bad News

- There needs to be further education and training on communicating with, and caring for, patients with palliative care and end of life needs. Staff need further training in basic communication skills.

Utilising appropriate specialist resources i.e. Palliative Care Team

- It was suggested that peer support from the Palliative Care Team to other specialities (e.g. cardiology) would be helpful in outpatients clinics to check “we’re managing patients palliative care needs correctly”

Preferred Priorities of Care (PPC)

- Discussions regarding preferred place of care should be introduced at diagnosis.

Understanding Discharge Processes

- Nurses need to be better trained in discharging dying patients and doctors to be more informed and aware of what is appropriate for patients at end of life.

Support/ Advice / Information / Training for families and carers

- Staff need to be more sensitive in dealing with palliative care patients and families and their needs.
- There should be better support for families and carers both through education
- It was suggested that there should be an education and training programme for community pharmacists, to skill up the professionals to better support patients and their carers
- More support for carers and patients from district nurses and more training for them in end of life care.
- It was suggested that there should be better education for relatives/carers on what to expect in regards to deterioration in the patient's condition and who to contact in the event of an emergency/concern
- Families and carers should be educated around caring for their loved one, including what to expect and when to seek advice
- There is a need to actively involve and liaise with relatives in the discharge process, to be up front and honest with them regarding the patient's condition and to ensure they fully appreciate the implications of looking after their loved one at home. This would bring to light any additional support the family might need and better prepare them for managing the patient at home particularly in the event of a crisis.
- Patients and their families should be educated around what to expect from carers.

Continuing Health Care Funding

- There should be an increased understanding by ward nurses about continuing care funding.
- All staff need further training and information on continuing care
- Nursing staff need further training and awareness on the continuing care process.

Attendance and access to Education and Training sessions/events

- More pressure from senior management is needed to increase the uptake of training sessions. Currently, it is not seen as a priority.

Appendix 9: NHS Libraries in SE London

South East London Health Libraries

A List of NHS Libraries in South East London

London Health Libraries www.londonlink.ac.uk

The following are contact details of Libraries for NHS staff working in South East London. Unless you work in one of the following organisations, it is appropriate to contact the libraries before visiting them in person. If you do not work in the NHS, it may be possible to use some of the libraries but it is necessary to contact them to ascertain their membership regulations.

NHS Acute Trusts

Lewisham (*also provide services for Lewisham PCT)*
The Lewisham Hospitals NHS Trust
University Hospital Lewisham
The Library, Education Centre
Lewisham High Street
London SE13 6LH

Tel 020 8333 3030 extension 6454
Email library@uhl.nhs.uk

Orpington
South London Healthcare NHS Trust
Princess Royal University Hospital
The Library, Education Centre
Farnborough Common
Orpington, BR6 8ND

Tel 01689 864306
Email slh-tr.br-library@nhs.net
Web http://www.bromleyhospitals.nhs.uk/trust/fec/library

Sidcup
South London Healthcare NHS Trust
Queen Mary's Hospital
The Charnley Library, Frognal Centre
Sidcup, DA14 6LT

Tel 020 8302 2504
Email qms-tr@library.nhs.uk

Woolwich
South London Healthcare NHS Trust
Queen Elizabeth Hospital
Healthcare Library, Knowledge Services
Stadium Road, Woolwich
London SE18 4QH

Tel 020 8836 6748
Email library.geht@nhs.net (until April 2010)
Web http://selhl.nhs.uk/qeh

NHS Primary Care Trusts

Waterloo
Lambeth and Southwark Health Library
1st Floor
1 Lower Marsh
Waterloo
London SE1 7NT

Tel 020 3049 4450
Email learningcentre@lambethpct.nhs.uk
Web www.lambethpct.nhs.uk/about_nhs_lambeth/health_library
Library Catalogue www.selhl.nhs.uk/lsl

NHS Mental Health Trusts

Beckenham
Bethlem Royal Hospital
Bethlem Library, Bishopsgate Centre
Monks Orchard Road
Beckenham, BR3 3BX

Tel 020 3228 4817
Email bethlemlibrary@kcl.ac.uk

Dartford
Oxleas NHS FoundationTrust
Knowledge Services
Pinewood House, Pinewood Place
Dartford, DA2 7WG

Tel 01322 652700 extn. 5886
Email ann.porteous@oxleas.nhs.uk

Stockwell
South London and Maudsley Mental Health Foundation Trust
Lambeth Hospital
Multidisciplinary Library, Reay House,
108, Landor Road
London SW9 9NT

Tel 020 3228 6336
Email librarystaffreayhouse@slam.nhs.uk

Specialist Libraries

Southwark
Knowledge and information Centre
St Thomas' Hospital
Westminster Bridge Road
London SE1 7EH

Tel 020 7188 3418
Email kic@gstt.nhs.uk

Sydenham
Halley Stewart Library
(End of life, bereavement, palliative care)
St Christopher's Hospice
51-9, Lawrie Park Road, Sydenham
London SE26 6DZ

Tel 020 8768 4660
Email d.brady@stchristophers.org.uk
Web http://www.stchristophers.org.uk/page.cfm/link=107

Higher Education

Camberwell
Institute of Psychiatry
King's College London
De Crespigny Park
London
SE5 8AF

Tel 020 7848 0204
Email nhsenquiry@kcl.ac.uk

King's College London (Denmark Hill Campus)
Information Services Centre
Weston Education Centre
Cutcombe Road,
London SE5 9RJ

Tel 020 7848 5541/2
Email nhsenquiry@kcl.ac.uk

Elephant and Castle
London South Bank University
Perry Library
150, Southwark Bridge Road
London SE1 9NJ

Tel 020 7815 6615
Email library@lsbu.ac.uk

(October 2009. Amended by Denise Brady, St Christopher's Hospice from draft list compiled by Marlene Blackstock at Kings College London, Denmark Hill Campus)

Eltham
University of Greenwich
Avery Hill Campus Library
Mansion Site
Bexley Road
Eltham
London SE9 2PQ

Tel 020 8331 8484
Email ahlibrarians@gre.ac.uk
Web www.gre.ac.uk

London Bridge
King's College London (Guy's Campus)
Information Services Centre
New Hunt's House
London SE1 1UL

Tel 020 7848 6600
Email nhsenquiry@kcl.ac.uk

Waterloo
King's College London (St Thomas' Campus)
St Thomas' Hospital
Information Services Centre
St Thomas House
Westminster Bridge Road
London SE1 7EH
Tel 020 7188 3740
Email nhsenquiry@kcl.ac.uk

King's College London (Waterloo Campus)
Information Services Centre
Franklin-Wilkins Building
150, Stamford Street
London SE1 9NH
Tel 020 7848 4378
Email nhsenquiry@kcl.ac.uk

Appendix 10: Summary of mapping results; SE London Palliative & End of Life Care Courses, 2007-8

NB. Medical training at KCL and in collaboration with acute trusts is summarised in separate table on page 172

Abbreviations

AHPs = Allied Health Professionals	**KCH** = King's College Hospital	**QEH** = Queen Elizabeth Hospital, Woolwich
CSCI = Commission for Social Care Inspection	**KCL-DPR** = King's College London, Dept of Palliative Care Policy & Rehabilitation	**QMS** = Queen Mary's Sidcup
ELH = EllenorLions Hospice	**KCL-FNSNM** = King's College London, Florence Nightingale School of Nursing & Midwifery	**RGNs** = Registered General Nurses
EoLC = End of life Care	**LSLCHST** = LSL Care Homes Support Team	**SALT** = Speech & Language Therapist
GBCH = Greenwich & Bexley Cottage Hospice	**MCCC** = Marie Curie Cancer Care	**SLAM** = South London & Maudsley NHS Foundation Trust
GSTT = Guy's & St Thomas' Hospitals	**MCS** = Macmillan Cancer Support	**SPCT** = Specialist Palliative Care Team
HCAs = Health Care Assistants	**MultiP** = Multiprofessional	**StC** = St Christopher's Hospice
HHC = Harris Hospiscare	**PRUH** = Princess Royal University Hospital	**UHL** = University Hospital Lewisham

COURSE TOPICS & NUMBER OF COURSES	ORGANISATIONS / TEAMS RUNNING & DELIVERING COURSES	RANGE OF FREQUENCY OF COURSES	TYPES OF STAFF DELIVERING COURSES	INTENDED AUDIENCE per course	CATCHMENT AREA FOR AUDIENCE	COURSES ACCREDITED?	RANGE OF LENGTH OF COURSE	RANGE OF NUMBER OF PLACES AVAILABLE	RANGE OF COSTS PER TAUGHT DAY EQUIVALENT
Discussions as the end of life approaches									
3 x Communication -advanced level	2x KCL- FNSNM	Annually	Nurses & lecturers	1x multiP, 1x RGNs	Open access	Yes- all via Connected & with KCL (level 7 courses)	2 to 7 taught days	10- 15 places	£75
	1x SE London Cancer Network with 'Connected' & others	10 times per year	Nurses, doctors, lecturers	Multi-professional	SE London senior cancer clinicians	Yes, via Connected	3 taught days	Approx 10	£134 though free at delivery
9 x Communication- basic & intermediate	2x MCCC 1x MCS	1 -2 per year / As per demand	Lecturers	1x multiP, 1x HCAs, 1x volunteers	Open access	No	1 taught day	16- 20; one course not specified	2x £25, 1x free
	1x GBCH 1x HHC 1x StC 1x GBCH / ELH	Annually – 6 times per year	3x multiP, 1x Palliative Care Social workers	1x QEH medical students, 1x non-clinical support staff, 1x Bexley GPs, 1 x multiP	1x QEH medical students only, 1 x Bexley GPs, others open access	No	1 hour to 1 day	10- 20, two courses not specified	Free- £90
	1x QMS SPCT 1x PRUH SPCT	1-2 per year	1x multiP, 1x not specified	1x AHPs, 1x mulitP	1x QMS & Bexley PCT, 1x not specified	No	1 -1.5 hours	14- 15	Free
1x Communication- specifically breaking bad news	QMS SPCT	Twice per year	Doctor	Medical staff- student & qualified	QMS only	No	1 hour	Approx 12	Free
1x Advance Care Planning	StC	8 per year	Not specified	Care home, hospital, & community generalist staff	Open access	No	1 day	Not specified	Not specified

COURSE TOPICS & NUMBER OF COURSES	ORGANISATIONS / TEAMS RUNNING & DELIVERING COURSES	RANGE OF FREQUENCY OF COURSES	TYPES OF STAFF DELIVERING COURSES	INTENDED AUDIENCE per course	CATCHMENT AREA FOR AUDIENCE	COURSES ACCREDITED?	RANGE OF LENGTH OF COURSE	RANGE OF NUMBER OF PLACES AVAILABLE	RANGE OF COSTS PER TAUGHT DAY EQUIVALENT
Assessment, care planning & review									
5x Palliative Care Needs: disease specific	2x StC (Dementia/Cancer)	Once per year	1x multiP, 1x complementary therapists	1x multiP, 1x complementary therapists	Open access	No	6.5 hours- 1 day	Not specified	£90- £100
	KCL-FNSNM (Elderly)	Once per year	1x MultiP incl chaplain & funeral director	RGNs & AHPs	Open access	Yes- KCL	1 day	Approx 15	Not specified
	SLAM / StC (Dementia) KCH / StC (MND conference)	1x Once & 1x 3 times per year	1x StC Dementia Nurse Specialist, 1x doctors	1x mental health of older adult services staff, 1x multiP	1x in-house, 1x open access	No	3 hours- 1 day	Approx 15 / not specified	Free / not specified
6x Drug and Symptom Control [general]	2x MCCC	Once per year	Lecturers	1x qualified clinical staff & pharmacists, 1x RGNs	Open access	No	1 day	16- 20	£25
	1x HHC 2x GBCH	Once to 12 per year	1 x Nurses & doctors, 2 x nurses	1x RGNs & AHPs, 1x RGNs, 1x HCAs	1x Open access, 2x Greenwich tPCT clinical staff	No	4- 4.5 hours	15- 20	1x not specified, 2x free as commissioned
	1x KCL-FNSNM	Once per year	Lecturer, nurses, doctors	RGNs	Open access	Yes- KCL (level 6 module)	6 taught days	Approx 12	£125
9x Drug and Symptom Control [specific]- incl pain, chronic oedema, cachexia, breathlessness	1x MCCC	Once per year	Lecturers, nurses, doctors	RGNs	Open access	No	1 day	20	£25
	1x QMS SPCT 1x PRUH SPCT	Once per year	Doctor & not specified	1x medical staff- qualified, student & GPs, 1x physios	1x QMS + Bexley & Bromley PCTs, 1x not specified	No	45 minutes to 1 hour	8- 30	Free, not specified
	4x HHC 1x GBCH 1x StC / KCH SPCT	Once per year, 1 course twice per year	5x multiP, 1x nurse & external lecturer	5x multiP, 1x RGNs	Open access	No	4 hours- 3 days	15- 20, 1x course unspecified	Free - £90, unspecified for 5 courses
13x Drug and	1x LSLCHST / StC	Once per year	Nurses	RGNs in care homes	LSL care homes only	No	0.5 day	50	Not specified

Symptom Control [syringe drivers]	1x QEH SPCT 1x KCH SPCT 2x UCL SPCT 1x QMS SPCT 1x PRUH SPCT 1x GSTT SPCT	Weekly- Once per year	5x Nurses, 1x doctor, 1x not specified	1x medical students, 1x RGNs & student nurses, 1x hospital RGNs, 1x primary care RGNs, 1x doctors- qualified & students, 1x medical students & RGNs, 1x clinical staff	5x hospital staff only, 1x DN teams that work with UHL SPCT, 1x unspecified	No	1 hour to 1 day	10- unlimited	Free
	1x HHC 3x ELH 1x GBCH	Once to eight times per year; 1x course on request	1x not specified, 1x lecturer, 1x lecturer & nurses, 1x lecturer doctors & nurses, 1x nurses	1x nursing home staff & community RGNs, 2x RGNs, 1x RGNs & doctors	1x not specified, 1x Bexley Care Trust RGNs, 2x open , 1x open access, 1x QEH staff only	No	1- 2.5 hours, 1x not specified	7- 30, 1x not specified	Free- £10 per 3 hours, 2x not specified
2x Emergencies in cancer palliative care	QMS SPCT	Once per year	Doctor	Medical staff- student & qualified	QMS only	No	1 hour	Approx 30	Free
	HHC	Once per year	MultiP	MultiP	Open access	No	4 hours	20	Not specified
2x Palliative Care Rehabilitation	HHC StC	Once per year	1x not specified, 1x doctors physios & AHPs	1x multiP, 1x primarily AHPs in oncology / Palliative Care	1x not specified / 1x open access	No	1x not specified, 1x 1 day	12, 1x not specified	Not specified / £100
2x Palliative wound care- introductory / advanced	StC	Once per year	Nurse consultant, nurse &research fellow	RGNs	Open access	No	1 day	Not specified	£90
2x Nutrition	StC ELH	Once to three times per year	1x Director of Nursing, dietitian, SALT, 1x not specified	MultiP	Open access	1x no, 1x yes- the Chartered Institute of Environmental Health	1 day	1x not specified, 15	£90, 1x not specified

1x Prognostication	StC	Once per year	Lecturers & medical consultants	Clinicians	Open access	No	1 day	Not specified	£90
1x Non medical prescribing in end of life care	StC	Once per year	Nurse & medical consultants, nurse manager, pharmacists	Non-medical prescribers	Open access	No	1 day	Not specified	£90
1x Do-not-attempt-resuscitation policy training	ELH / GBCH	Twice per year	Lecturer & multiP	RGNs	In-house + Bexley Care Trust staff	No	1 day	Approx 20	Free-commissioned by PCT

COURSE TOPICS & NUMBER OF COURSES	ORGANISATIONS / TEAMS RUNNING & DELIVERING COURSES	RANGE OF FREQUENCY OF COURSES	TYPES OF STAFF DELIVERING COURSES	INTENDED AUDIENCE per course	CATCHMENT AREA FOR AUDIENCE	COURSES ACCREDITED?	RANGE OF LENGTH OF COURSE	RANGE OF NUMBER OF PLACES AVAILABLE	RANGE OF COSTS PER TAUGHT DAY EQUIVALENT
Coordination of care / Delivery of high quality services in different settings									
7x Models of care and developing care & services	6x StC (incl developing: care homes, day care, Gold Standards Framework- GSF; primary care & care homes, libraries in hospices, complementary therapy) 1x GBCH (GSF)	Once per year, 1x every fortnight	2x RGNs, 1x day care director, research officer, director of nursing & CEO, 1x doctors & RGNs, 1x librarian staff, 1x complementary therapists / RGNs, 1x RGNs & HCAs	2x general care home staff, 2x multiP, 1x GPs, 1x hospice library staff, 1x care home coordinators for GSF in care home (GSFCH) programme	5x open access, 1x any UK GSFCH coordinators, 1x Greenwich & Bexley Care Home staff	No for all except GSFCH course which is validated by national GSF team	1 hour to 1 day; GSFCH course involves 4 whole day work shops over 12 month period	Not specified	Free- £100; Costs for GSFCH WHOLE programme are: <30 beds = £900, 31- 60 beds = £1000, 61- 90 beds = £1200, 91- 120 beds = £1400
4x Role of & Referral Processes to Specialist Palliative Care Teams	1x UHL SPCT 1x KCH SPCT 2x QEH SPCT *NB. All as part of staff induction*	Twice per year to monthly	2x RGNs, 2x RGNs & doctors	2x junior doctors, 1x RGNs & HCAs, 1x all staff	With individual acute trust only	No	15- 30 minutes	10- unlimited	Free
Care in the last days of life									
16x Care in Last Days of Life [incl LCP in majority]	1x LSLCHST / StC	Twice per year	MultiP	Care home RGNs & HCAs	LSL care homes only	No	1 day	50	Not specified
	2x KCH SPCT 2x UHL SPCT 1x QMS SPCT 1x PRUH SPCT	Weekly to twice yearly, 1x unspecified	2x MultiP, 2x not specified, 1x RGNs, 1x doctors	1x RGNs, 1x not specified, 2x medical staff- qualified & students, 1x RGNs & AHPs, 1x multiP	Individual hospitals only	No	20 minutes to two hours, 1x not specified	2- unlimited	Free; 1x not specified

	1x HHC 6x GBCH	Weekly to once per year	1x not specified, 2x RGNs, 1x multiP (incl 2 courses with input from PCT EoLC leads & CSCI)	1x care home staff, 1x care home RGNs, 1x care home managers, 1x GBCH clinical staff, 3x QEH staff-multiP + student nurses + RGNs	1x care homes in Bromley, 3x open access to care homes, 1x GBCH staff only, 2x QEH only	No	1 hour to five days, 1x not specified	12 – unlimited, 1x not specified	Free; 1x not specified
	2x SLAM	Once to twice per year	1x community matrons, 1x Care home nurse specialists & modern matrons	Mental Health for Older Adults Services- 1x for general staff & 1x for band 5 RGNs	In-house only	No	3 hours to 0.5 day	Approx 12	Free as sourced in-house
Care after death									
19x Loss, grief and bereavement	1x MCCC	1- 2 times per year	Lecturer	MultiP	Open access	No	1 day	27	£25
	1x GBCH	Once per year	Psychosocial staff	Hospice volunteers	In house only	No	6 x 2 hours	6	Free
	1x StC- with Help the Hospices & Michael Sobell House, Oxford	Once per year	Lecturers & psychiatrist	Bereavement workers, academics, all health & social care staff	Open access	Yes- Postgraduate certificate: working with bereaved adults; with Middlesex University	2 x 5 days over 9 months	Not specified	Not specified
	1x StC – with Help the Hospices	Once per year	Lecturer & Candle Project staff	MultiP	Open access	Yes- Under/Post graduate diploma: Childhood Bereavement; with Middlesex University	8 taught days over 1 academic year	Not specified	FOR WHOLE MODULE: Undergraduate- £1700 Postgraduate- £2000

	1x StC- with 'Respond' [Bereavement Care for people with learning disabilities & Autistic Spectrum Disorders	Once per year	Drama therapist & lecturer	Those with baseline knowledge of recent bereavement theory and counselling skills	Open access	No	5 days	Not specified	£90
	1x StC with Utrecht University [Grief Research & Bereavement Care]	Once per year	Psychiatrist, Prof of Psychology, Head of Education	MultiP	Open access	No	1 day	Not specified	£150
	11x StC *- including Schools & bereavement, Young people facing bereavement, working with children facing loss, working with bereavement in Prison Chaplaincy, complicated grief*	Once per year; 3x one off courses	2x StC Candle Project staff (CPs), 1x StC CPs, Clinical Director & Creative Living team, 3x StC CPs, & Palliative Care SWs, 1x research fellow, psychiatrist & other psychological support professionals, 1x StC CPs & spiritual care workers, 1x spiritual care workers, 2x not specified	1x primary school based staff, 1x secondary school based staff, 1x those working with school children, 3x not specified, 1x workers with young people, 2x all interested, chaplaincy workers in contact with young people, 1x prison chaplains	Open access	No	0.5- 1 day	Not specified	£90; 2x not specified
	2x KCL-FNSNM	Once per year	1x lecturer & nurse, 1x lecturer	RGNs	Open access	1x yes: Facing transition & loss- level 6 module- KCL 1x no: Death, dying & bereavement	3- 6 taught days	12- 15	Level 6 module: £750 TOTAL Non-accredited course cost not specified

COURSE TOPICS & NUMBER OF COURSES	ORGANISATIONS / TEAMS RUNNING & DELIVERING COURSES	RANGE OF FREQUENCY OF COURSES	TYPES OF STAFF DELIVERING COURSES	INTENDED AUDIENCE per course	CATCHMENT AREA FOR AUDIENCE	COURSES ACCREDITED?	RANGE OF LENGTH OF COURSE	RANGE OF NUMBER OF PLACES AVAILABLE	RANGE OF COSTS PER TAUGHT DAY EQUIVALENT
Overarching themes									
35x Principles of Palliative and End of Life Care	3x MCCC (1 general, 1 cancer focused, 1 focused on non-cancer diseases)	Once to twice per year	2x lecturer, 1x lecturer & clinicians	1x RGNs, 1x HCAs, 1x RGNs & AHPs	Open access	No	1- 2 days	16- 20	£25
	1x Help the Hospices (CLIP- comprehensive Palliative Care e-learning course)	N/A as e-learning	N/A	MultiP	Open access as e-learning	No	58x 15 minute e-learning tutorials	N/A	Free
	1x MCCC	Not specified	Self-directed learning as distance learning course	Not indicated	Open access	Designed with Open University- ? accredited	Not specified	N/A	Free
	1x KCH SPCT 2x PRUH SPCT	Monthly to once per year	2x not specified, 1x multiP	1x multiP, 1x RGNs, 1x HCAs	Within acute trust only	No	3- 8 hours	10- 15	Free
	1x HHC 5x ELH 5x SCH 7x GBCH	Once per year to 24 times per year	5x lecturer + multiP, 5x multiP, 3x RGNs, 2x medics, 1x AHPs, 1x multiP + CSCI, 1x not specified	5x multiP, 2x RGNs, 3x HCAs, 1x care agency staff, 1x AHPs, 1x medics, 1x HCAs / support workers/ admin staff, 1x GP trainees, 2x RGNs in care homes, 1x student nurses	1x not specified, 3x Bexley staff, 3x open access, 2x open access for HCAs, 1x S London GPs, 1x hospice in house, 2x Greenwich & Bexley staff, 1x Greenwich community matrons, 3x QEH staff, 1x open access- care home managers	2x CPD approved, all others no	1.5 hours **to** course that includes 6.5 taught days with1 practice based day & follow up case reviews every 3 months	10- 30, 6x not specified, 3x specify 'unlimited'	3x not specified, Free- £300, 1x free as in-house training NB. 2x commissioned by PCT

	2x SCH with Palliative Care Pharmacists Network	Once per year	Palliative Care Pharmacists	1x Palliative Care Pharmacists, 1x generalist pharmacists	Open access to pharmacists	No	1 day	Not specified	£25- £90
	1x SCH / KCH SPCT / GSTT SPCT / Lambeth, Croydon, Southwark & Lewisham PCTs	One off	MultiP, including Macmillan GP Facilitators	GPs from Lambeth, Croydon, Southwark & Lewisham PCTs	Lambeth, Croydon, Southwark & Lewisham PCTs- GPs	No	1 day	Not specified	£25
	1x ELH / University of Kent, 1x SCH / KCL-DPR, 1x KCL-FNSNM with 2 modules in collaboration with SCH, 1x SCH / Bromley College	Once to three times per year	1x lecturer, 1x lecturer + multiP, 1x lecturer + nurses, 1x nurse tutor & hospice clinicians	2x multiP, 1x RGNs, 1x HCAs	2x open access, 1x open access for RGNs, 1x open access for HCAs	Yes: 1x University of Kent (MSc module), 1x KCL-DPR (MSc, PGDip, PGCert), 1x KCL- FNSNM (MSc, PG Dip, PG cert), 1x Bromley College (NVQ 2-3)	3 days **to 'max of 5 years to finish- MSc = 1800 hours, PGDip = 1200 hours, PGCert = 600 hours**	3x not specified, 10- 35	1x not specified, £90 per day (Bromley College course), For KCL- DPR (Whole course): MSC: UK/EC: £3,650 Overseas (non-EU): £13,5000 Diploma: UK/EC: £2,435 Overseas (non-EU): £9,000 Certificate: UK/EC: £1,220 Overseas (non-EU): £4,500
	2x KCL- FNSNM	Once per year	1x Lecturers + nurses, 1x multiP	2x RGNs + AHPs	Open access for RGNs / AHPs	Yes- KCL-FNSNM (1x level 6 module, 1x accredited)	3- 6 taught days	10- 15	1x not specified, 1x £125
3x Spiritual and cultural care; including equality & diversity	1x MCCC, 2x SCH	Once per year	1x lecturer + spiritual care coordinator, 1x lecturer, RGN, spiritual care consultant, 1x spiritual care workers	1x multiP, 2x spiritual care workers	1x open access, 2x open access for chaplains & spiritual care workers	No	1 to 5 days	2x not specified, 1x 20	£25- £100

COURSE TOPICS & NUMBER OF COURSES	ORGANISATIONS / TEAMS RUNNING & DELIVERING COURSES	RANGE OF FREQUENCY OF COURSES	TYPES OF STAFF DELIVERING COURSES	INTENDED AUDIENCE per course	CATCHMENT AREA FOR AUDIENCE	COURSES ACCREDITED?	RANGE OF LENGTH OF COURSE	RANGE OF NUMBER OF PLACES AVAILABLE	RANGE OF COSTS PER TAUGHT DAY EQUIVALENT
7x Ethical Issues (including 3x focused on mental capacity act)	1x QMS SPCT 1x QEH SPCT	Once - twice per year	1x multiP, 1x doctor	1x multiP, 1x medics- student & qualified	1x QMS staff, 1x QEH + Greenwich PCT staff	No	1 hour – 1 day	14- 25	Free (NB. One course commissioned for Greenwich PCT staff)
	1x HHC 1x GBCH 1x SCH 1x ELH	Once – twice per year	1x lecturer + doctors, 1x not specified, 2x multiP	MultiP	3x open access MultiP, 1x open access within Bexley	No	1 hour – 1 day	12- 20, 2x not specified	Free- £100, 1x not specified
	1x Help the Hospices & National Council for Palliative Care	N/A as e-learning	N/A as e-learning	MulitP	Open access as e-learning	No	Self-directed learning	N/A	Free
12x Psychological & social care (including use of Cognitive Behavioural Therapy)	1x MCCC	Once per year	Lecturer	MultiP	Open access	No	1 day	20	£25
	1x HHC 6x SCH	Once per year	2x multiP, 1x Palliative Care SWs, 1x SWs & psychological support staff, 1x psychological & bereavement support staff, 2x day care & psychological support staff	6x multiP, 1x Palliative Care Clinicians	6x open access, 1x open access to Palliative Care clinicians	No	4 hours - 1 day	1x 20, 6x not specified	£90- £100, 1x not specified
	3x SCH / Institute of Psychiatry, Maudsley Hospital	Once per year	2x doctor, psychotherapist + nurse / Cognitive Behavioural Therapist, 1x Consultant Psychiatrist	1x oncology & palliative care clinicians, 2x therapists in palliative care	Open access	No	2- 3 days	Not specified	£90- £100

	1x KCL- FNSNM	Once per year	Lecturer + RGNs + Sociologist	RGNs & AHPs	Open access	Yes- KCL-FNSNM (Level 6 module)	6 taught days	@15	£750 FOR THE WHOLE MODULE
1x Evidence based care in Palliative Care Nursing	1x SCH	Once per year	RGNs	Specialist Palliative Care Nurses	Open access	No	1 day	Not specified	£100
1x Changing attitudes & dispelling myths- death and dying	1x SCH	Once per year	Lecturers, Doctors, day care staff	MultiP	Open access	No	1 day	Not specified	£90
8x Learning through clinical placements or visits	1x KCH SPCT 1x UHL SPCT 1x QMS SPCT 1x GSTT SPCT	2x not specified, 2x on request	3x not specified, 1x SPCT	1x student nurses or visitors from abroad, 1x multiP, 1x student nurses, 1x not specified	1x KCL student nurses or visitors from abroad, 1x UHL or Lewisham PCT clinical staff, 1x QMS student nurses, 1x not specified	No	1 day or multiple day – up to a week, 2x not specified	Not specified	Free
	1x HHC 1x GBCH 1x ELH 1x SCH	3x not specified, 1x on request	1x ward / day therapy staff, 1x ward staff, 2x not specified	1x not specified, 1x multiP including overseas clinicians, 1x mainly doctors & nurses, 1x RGNs & care home staff	2x not specified, 1x those attending education programme, 1x open access	No	2x not specified, 1x 1-2 days, 1x minimum 5 days	3x not specified, 1x 11 during 2008	3x not specified, 1x free

Appendix 11: Summary of mapping results; Medical education/training mapping- King's College London

All KCL medical students (approximately 400 per annum) have the following education and exposure to end of life care. This is delivered both within the School of Medicine and at acute trusts across South East London and Kent.

Pre-clinical years 1-2	
Introductory seminar and hospice visit	6 hours
Lecture and video on loss	2 hours
Clinical year 4	
Symptom control	1 hour
Dying patient symposium- lecture/video/group work	4 hours
Chronic Pain Symposium	3 hours
Bedside clinical teaching by specialists	2 hours
OSCE – history taking short case: 1 exam station	
Optional special study module (SSM) - tailored self directed learning *Possible components include:-* *Symptoms e.g. pain, anorexia* *Ethics* *Diverse clinical/diagnostic groups* *Diverse care settings*	4hrs pw per term
Year 5 – consolidation of learning from previous years	
Hospice visits	4 hours
Lecture/symposium	3 hours
Optional – access to specialist palliative care SpR's for informal teaching/tutorials etc.	
Ethics and Law BSc	
Single clinical placement on King's site	24hrs total pa
Post graduates – FY1	
Induction – introduction to LCP	Variable across sites- details incorporated into general mapping table above
Rolling teaching – introduction to the service	
Access to SpR's/shadowing opportunities	
Lewisham Site F1/2	1 hr / pa
Post-graduates – ST1/2	
Induction oncology /haematology – intro to service	15 minutes
MSC in Palliative Care (multiprofessional Specialist Palliative Care)	
Core symptom control module	6 hrs / pa
Core psychosocial module (ethics)	7 hours

Appendix 12: Summary of mapping results: Courses and teaching sessions planned by South East London education providers for 2009

The Queen Mary's Sidcup SPT:

- Care of the dying study day for qualified nurses
- Syringe-driver workshop for qualified nurses
- LCP workshop for HCAs & qualified nurses
- Care of the dying study day for HCAs

St Christopher's Hospice:

- Gold Standards Framework in Care Homes; phase 5a & 5b (90 care homes represented)
- Training the Trainers in Advance Care Planning
- Supportive care skills course (3 day course with the GSF National Team)
- GPs in nursing homes
- Innovation: defining, developing & demonstrating supportive care at the end of life
- Training for activity co-ordinators in care homes
- Music therapy in end of life care
- Personalisation agenda
- Advanced course for HCA's- imaginative approaches to end of life care
- Working with families- master class
- Depression
- End of Life Care Conference for nurses at Olympia
- Dementia & Spirituality

EllenorLions Hospice:

- Contributing to pre-reg. training at Canterbury Christ Church University on EOLC module
- Psychological care workshops

Macmillan Cancer Support:

- Course on leadership & strategic development
- Influencing skills for Macmillan Professionals
- Possibly offering coaching & learning sets for Macmillan professional leaders
- New E-learning opportunity: Family & the law; exploring the legal requirements for children when an adult has cancer

Greenwich & Bexley Cottage Hospice:

- Palliative Care training for community matrons- commissioned by PCT
- Palliative care training for social care staff- commissioned by Local Authority
- Palliative Care education (including communication skills) for Bexley GPs
- Palliative Care training for HCAs
- 6 month D-grade development programme for newly qualified staff with an interest in palliative care
- Medicines management for paediatric teams
- Palliative Care Training for GP trainees
- LCP for Community staff (GPs, DNs, Care Home Staff)
- Palliative Care Training for Bexley DN Service – in conjunction with EllenorLions Hospice